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**INTEGRATING PROFESSIONAL AND MANAGERIAL
EXPERTISE:
SHIFTING BOUNDARIES IN UK HEALTH AND SOCIAL
SERVICES**

Sue Llewellyn

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**DOCTOR OF PHILOSOPHY
(BY RESEARCH PUBLICATIONS)
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DECLARATION:

I confirm that the work submitted for this thesis has not been submitted in whole or in part for the award of another degree.

Sue Llewellyn

The critical review covers the following published papers:

1. Llewellyn, S. (1993) Working in Hermeneutic Circles in Management Accounting Research: Some Implications and Applications, *Management Accounting Research*, Vol. 4, pp. 231-249.
2. Llewellyn, S. (1994) Managing the Boundary: How Accounting is Implicated in Maintaining the Organization, *Accounting, Auditing and Accountability Journal*, Vol. 7, No. 4, pp. 4-23.
3. Llewellyn, S. (1997) Purchasing Power and Polarized Professionalism in British Medicine, *Accounting, Auditing and Accountability Journal*, Vol. 10, No. 1, pp. 31-59.
4. Llewellyn, S. (1998a) Boundary Work: Costing and Caring in the Social Services, *Accounting, Organizations and Society*, Vol. 23, No. 1, pp. 23-47.
5. Llewellyn, S. (1998b) Pushing Budgets Down the Line: Ascribing Financial Responsibility in the UK Social Services, *Accounting, Auditing and Accountability Journal*, Vol. 11, No. 3, pp. 292--308.
6. Llewellyn, S. (1999) Surgeons are Counters, Physicians are Philosophers, *Research in Healthcare Financial Management*, Vol.5, No.1, pp. 25-40.

Note 1: This submission meets Regulation 3.11.13 of the PhD (by Research Publications), as the candidate is the sole author of these six publications.

Note 2: The critical review shows how these publications form a coherent body of knowledge (Regulation 3.11.14). In this regard, publications 3, 4, 5 and 6 are all empirical papers set in the public sector (3 and 6 in health care, 4 and 5 in the social services). All four papers are concerned with the boundary between professional and managerial work in public services and how that boundary is changing consequent upon devolved budgeting. Publication 1 sets out the interpretative methodology that underpins the empirical work. Publication 2 gives a theoretical understanding of the nature of boundary work.

Note 3: Where these papers are cited in the thesis they are italicized to aid identification by distinguishing them from other published work by the author.

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ABSTRACT

INTEGRATING PROFESSIONAL AND MANAGERIAL EXPERTISE: SHIFTING BOUNDARIES IN UK HEALTH AND SOCIAL SERVICES

DEGREE OF PhD (BY RESEARCH PUBLICATIONS)

Public sector reform has involved both a re-negotiation of the boundary between managerial and professional work and a re-thinking of the relationships between practising professionals and managerial professionals. This thesis is concerned with the nature of the boundary work that has led to a greater integration between professional and managerial expertise in public services. It is argued that management and professional discourses are organized around the central principles of “costing” and “caring”, respectively. “Costing” is the key focus for managers as they grapple with resource constraints; whilst “caring” is the fundamental concern for professionals in their work with clients/patients. Any integration must address “costing” and “caring” as the entry points to the domains occupied by managers and professionals.

The aims of the thesis are first, to understand how the boundary between professional and managerial work in the public sector has been constituted (including an exploration of how that boundary is changing) and, second, to trace at the interface between professional and managerial domains the impact of boundary work through budgets. The empirical work on which this thesis is based was carried out in two different areas of the UK public sector: health and social services. The thesis concludes that boundary work has been achieving integration primarily through the devolution of budgets that create boundary roles (e.g. care managers, GP fundholders and clinical directors). It is argued that budgets, money and numbers can be powerful integrators across the boundary between professional and managerial expertise in public services.

CRITICAL REVIEW INTRODUCTION

There is overwhelming evidence, on an international scale, that the public sector is being reformed, and that a prime aspect of this reform is an increasing managerialization (Hood, 1991, 1995; Clarke et al, 1994; Clarke and Newman, 1997; Humphrey and Olsen, 1995; Oakes et al, 1998; Olsen et al, 1998; Brunsson and Sahlin-Andersson, 2000). The public sector has become subject to intense pressures for change as Keynesian-type welfare state provision declines (Hopper, 1999). This reforming of public services has introduced more managerial expertise, but the status of management (and managers) is not totally secured. The public sector continues to have a foremost and fundamental reliance on professional labour (Newman and Clarke, 1994; Harrison and Pollitt, 1994; Leverment and Ackers, 2000). However, despite the continuing primacy of the professionals in delivering public services to individual patients/clients, management has gained ground in terms of its influence over setting the organizational framework for these services (Exworthy and Halford, 1999, p.1). The public sector is now dependent upon two broad categories of workers who, amongst other pursuits, currently vie for organizational supremacy: practising professionals and managerial professionals¹. This thesis is concerned with the shifting boundary both between these two types of worker and between the work that they do.

In this thesis practising professionals and managerial professionals² are both regarded as different types of expert (Abbott, 1988, Schön, 1991). Professional and managerial tasks are not seen in opposition to each other but as complementary and, frequently, as potentially overlapping (Davies, 1983; Scott, 1985; Hafferty, 1988; Scarbrough, 1995). However, the traditional concordat between professionals and managers in the public sector has been closer to an agreement to work along “parallel tracks” rather than a plan to integrate endeavours (Clarke et al, 1994; Harrison and Pollitt, 1994; *Llewellyn, 1998a, 1998b*). Hence the management of expertise in the public sector presents, in the first instance, an integration challenge. Integration between practising professionals and managerial professionals involves some dissolution of the closure they achieve to protect their knowledge base, status and internal group cohesion (Scarbrough, 1995, p.7).

Integration seeks active connections. The governing principle of integration dictates that things that were previously separate shall be aligned and put together (Bernstein, 1971).

¹ For example, in the health service, the dominant practising professionals are senior clinicians with general managers as the most powerful managerial professional group.

Adherence to this governing principle implies that, within areas of knowledge, purity is set aside in the pursuit of relevance (Beattie, 1995). Cooper et al (1996) argue that integration is constituted by mechanisms (or processes) through which some kind of unity is achieved between different organizational groups and their associated areas of expertise. Boundaries to areas of expertise are always "...scenes of potential instability." (Power, 1990, p.117). Impure, weakly classified knowledge ("dangerous knowledge" (Johnston, 1978)) is pushed to the boundary. So positioned, such knowledge becomes available for re-combination within another area of expertise. For this reason, it is at the boundary that integration (or differentiation) begins³. In this thesis, the processes through which articulations are constructed between professional and managerial concerns (Clarke and Newman, 1997) are studied as boundary work.

Integration also implies that the activity of management crosses the professional/manager divide, i.e. that managers manage professionals but, also, that professionals manage managers and that both professionals and managers manage themselves. Integration is studied as a condition achieved through boundary work as the division between practising professionals and managerial professionals is permeated. In any possible permeation, "costing" and "caring" have formed the "entry points" (Amariglio et al, 1993, p. 164) to the domains of management and professionalism, respectively. Amariglio et al (1993, p.164-165) define an entry point as, "...a concept or concepts which a theorist uses to enter into, to begin, discourse about some object of analysis. This entry can be, but need not be, an essence- the primary truth or the primary determinant cause- in the discourse that results....An entry point is a concept which will distinctively shape the asking of all questions and which will condition (and be conditioned by) all other concepts within a discourse....From the point of view of one school or another, the content and use of the entry point may construct this school's attempts to define the limits of its discipline." Such a definition posits an entry point is a central organizing concept from which a discourse flows. Moreover, the limits of any domain are set by entry points- as they discriminate between activities that are thought to be intrinsic or extrinsic to the core domain purpose (Llewellyn, 1998a). In the context of professionals and managers in the public sector, "caring" is the key orientating concept for practising professionals in their work with patients/clients, whilst "costing" is the central focus for managers as they grapple with resource constraints. Entry points are pivotal to how

² Although, in this thesis the terms "practising professionals" and "managerial professionals" are preferred to "professionals" and "managers" as they indicate some (neglected) similarities between the two groups, for brevity and ease of exposition the latter set of terms are also sometimes used in the thesis.

³ For example, in the past, administrative expertise was pushed to the boundary of the clinical knowledge base. Doctors who assumed administrative tasks were generally regarded as failures (Harrison, 1999). But latterly a new area of expertise has developed at the administrative/clinical boundary, that of medical management (Llewellyn, 2001a).

the professionals themselves define and understand their work (*Llewellyn, 1998a*). Integration through boundary work between practising professionals and managerial professionals in the public sector must address entry points, as they are fundamental to the traditional divide between professionalism and managerialism.

Llewellyn (1994) and *Llewellyn (1998a)* explore the general nature of boundary work as an integrative process. *Llewellyn, 1998a* and *Llewellyn, 1997* focus on boundary workers (care managers, and GP fundholders, respectively) as an integrative role that mediates professional and managerial work⁴. *Llewellyn 1997, (1998a), Llewellyn, 1998b* and *Llewellyn, (2001a)* discuss boundary budgets as integrative mechanisms across professional and managerial work. Although boundary workers and boundary budgets as ways of integrating across boundaries are conceptually distinct, they tend to converge on the integrative power of budgets. This convergence occurs because boundary workers (care managers, clinical directors and GP fundholders) all hold budgets and accomplish much of their boundary work through the exercise of budgetary power.

The published works that this critical review discusses have a common focus on the changing constitution of the boundaries of expertise in the UK public sector. Two specific areas have been the subject of empirical work: health care (*Llewellyn, 1997; Llewellyn, 1999*) and the social services (*Llewellyn, 1998a; 1998b*). There is now a large (and growing) body of research that indicates that the impact of managerialism on the professions in the public sector is very varied (Crompton, 1990; Keep, 1992; Humphrey et al, 1993; Clarke et al, 1994; Johnes and Cave, 1994; Laughlin et al, 1994; Ferlie et al, 1996; Goddard, 1997). The “reform cocktail” (Klein, 1995, p.191) across the public sector has had different consequences dependent upon where it was imbibed! General research indications of a differential impact across public services point to a need for detailed empirical comparative work. This thesis aims to make a contribution in this area through a comparative focus on boundary work in the two domains.

Both health and social care have similar goals as they are directed towards therapeutic change but the professionals within them are located at very different power/knowledge intersections (Foucault, 1972; 1979; 1980; 1986- see first section under “Theoretical themes” for a discussion of the relationship between Foucault’s “power-knowledge intersections” and “boundary work”). Such circumstances indicate that there are sufficient commonalities to make a comparison between health and social services feasible but enough differences to

⁴ Llewellyn (2001a) continues this theme through looking at clinical directors as boundary workers.

make such a comparison fruitful. Health care is a more internally differentiated domain than the social services. Therefore, it is anticipated that the consequences of managerialism will be more varied in health than in social care (see *Llewellyn, 1999*). The differential impact of managerialism, both between health and social care and within health care itself, is explored in the later section: "Boundary work in the UK health and social services". The empirical studies (*Llewellyn, 1997; 1998a; 1998b and 1999*) all followed a qualitative, interpretative methodology. *Llewellyn (1993)* gives an account of a particular interpretative methodology: hermeneutics. A section in this critical review (p. 20ff) outlines how the methodology underpinning the empirical work described here relates to hermeneutics.

The focus of this thesis is on boundary work as an integrative process between practising professionals and managerial professionals. In this context it is necessary to understand the functions of boundaries for professional work. The boundaries between areas of expertise serve several purposes. First, boundaries differentiate mutually defining points of view (Cooper, 1990). Second, boundaries shape an area of expertise by controlling the type and degree of difference permitted within them (Messer-Davidow et al, 1993). Third, boundaries indicate which area of expertise (and which associated professional group) deals with which kind of problem. The first boundary function gives rise to the experts' sense of identity, including feelings of difference from others. The second fosters coherence and prevents fragmentation within the area of expertise. The third directs users of professional expertise to the "appropriate" area of knowledge. Several authors have argued that the divide between practising professionals and managerial professionals relates more to their modes of control rather than to their status as occupations (see, for example, Abbott, 1988; Crompton, 1990). This understanding supports the arguments of this thesis as it focuses interest on the boundaries between the two areas of expertise (rather than on the identification of supposedly unique occupational characteristics).

Boundary work may arise in several ways. First, there may be a political imperative for an occupational group to assume some of the tasks normally associated with another. Second, a new organizational role may be created that crosses previously distinct domains of expertise. Third, jurisdictional boundaries come under dispute as groups vie for the right to apply their knowledge (or judgement) to problems that may be addressed in more than one area of expertise. All three of these developments can be discerned in the discussion of the empirical papers (see p. 26ff). There have been political moves to encourage professionals to take on management responsibilities (e.g. the creation of GP fundholding and clinical directorates (*Llewellyn, 1997; Llewellyn, 2001a*)). New boundary roles have been instituted that mediate professional and managerial work (e.g. care managers, GP fundholders and clinical directors

(Llewellyn, 1998a; Llewellyn, 1997; Llewellyn, 2001a)). Negotiations over territorial issues have taken place between professionals and managers (e.g. managers vying with clinicians to decide the strategic direction of hospitals (Llewellyn, 2001a)). Moreover, professionals who have assumed new boundary roles have come into dispute with colleagues (e.g. GP fundholders' negotiations with hospital consultants over carrying out minor surgery in GP practices).

Aims of the study

In order to extend a discussion of boundary work, this thesis aims:

1. To understand, how the boundary between professional and managerial work in the public sector is constructed and maintained through a separation between the tasks of caring and costing (and to trace how that boundary is changing).
2. To trace, at the interface between professional and managerial domains, the impact of boundary work through budgets.

Two themes provide background theoretical understanding to the pursuit of these aims and are reflected in the published empirical work that this critical review discusses: the nature of boundary work; and the integrative power of numbers, money and budgets. These two themes are discussed next in turn. This critical review then moves to explore the comparative findings on boundary work in the empirical papers on health and social care before presenting a concluding discussion. However, first, the next section outlines some limitations of this thesis.

Limitations and reflexivity

The empirical papers on which this thesis is based were all researched and written after the introduction of the internal market in health care in 1991, consequent upon the 1989 White Paper *Working for Patients* and the introduction of contracting, along with the greater use of costing information in social services, following the Accounts Commission publication, *Squaring the Circle* in 1994. These initiatives for public services can be seen as part of a much wider political agenda to promote deregulation and to assert the values of the “free market” after several decades of national welfare and industrial concerns (Bonefeld and Holloway, 1996). This on-going political background created more receptive “conditions of possibility” (Foucault, 1980, p.243- see below) in public services for the introduction of a

greater degree of integration between professionalism and managerialism. The focus of the empirical papers is, largely, on this greater receptivity.

This limited focus does not deny, however, the existence of considerable professional resistance to managerial reform (for example, as a counterbalance to *Llewellyn, 1997*, see Broadbent et al., 2001 for a discussion of GP opposition to fundholding). The thesis is, also, not concerned with the deleterious consequences of more emphasis on financial accountability and less on professional accountability as a direct result of the reform of the public sector (see, for example, Ezzamel and Willmott, 1993). In summary, the work is directed solely towards understanding the areas where professionalism and managerialism may make a more useful engagement than they have to date and explicating the role of numbers, budgets, and money in this regard.

In looking at the, possibly, more enabling (than hitherto) role of money in social relations the thesis draws on the seminal work of Simmel but also uses some more contemporary sources, for example, Crump, Giddens, Gregory and Hart (see below for detailed discussion). Again, this does not deny the work of many authors on the negative impact of money on society. A key element in Marx's historical scheme was identifying the way in which "money makes money" in modern capitalist economies and how the resulting social relations are mystified, as inherent exploitation is hidden. Strange's (1986; 1997) work on *Casino Capitalism* points to the grave consequences on social and political systems when the inherent uncertainty of contemporary money markets makes gamblers of everyone, but causes an increase in inequities as some of us can cushion ourselves against this instability while others cannot. Lack of money is a prime determinant of social exclusion in society as it negotiates access to both economic and social resources and, hence, peoples' ability to participate in the wider community (Martin, 1999, p.12). There has been a rich tradition of work on the power of money to alienate and exclude in *exchange* relationships. However this thesis is primarily concerned with the possibility of using numbers, budgets and money as *resources* to integrate across disciplinary boundaries in organizations. It can be located within the broad tradition of using money as a solution to some of our contemporary problems (for another example in this genre see Hart's (2000) work on money as a collective memory bank where money becomes information and information money (p.3)).

THEORETICAL THEMES

Boundary work as theory

As argued above, traditional ways of working for professionals and managers in the public sector have tended to follow “parallel tracks” without plans to integrate endeavours (Clarke et al, 1994; Harrison and Pollitt, 1994; *Llewellyn, 1998a, 1998b*). Therefore the management of expertise in the public sector presents an integration challenge. How is integration achieved? The theory of boundary work enables understanding how practices of integration achieve active connections between previously separate “communities of knowing” (Boland and Tenkasi, 1995).

Managerial and professional communities of knowing are situated in different social worlds with disparate viewpoints and agendas. Boundary work occurs whenever interactions and co-operative effort between different communities results in some mutual renegotiation of their previously stable (and separate) identities. As boundaries operate inclusion/exclusion principles (Cooper, 1990), any flows of resources across boundaries offer opportunities for boundary work. Fujimura (1988, 1992) argues that concepts, skills, materials, techniques and instruments can all constitute resource flows. When members of different social worlds engage with any of these resources simultaneously they will be drawn into boundary work. This greater engagement, through the mutual exchange of resources, is shown in all four of the empirical papers in this thesis.

Llewellyn, (1997) is concerned with general practice fundholding. This initiative re-established the material, financial ties that had existed between GPs and consultants prior to the inception of the NHS in 1948 in the UK⁵. Once the consultants again received income from the GPs they became much more ready to engage with them over issues that had previously been problematic for the family doctors. Care management processes improved as communications from the hospitals to the GPs increased, for example, patient discharge letters were regularly sent out and new service information was disseminated. In the other direction, consultants became much more ready to hear the views of GPs, for example, on the appropriateness of certain secondary care procedures and regimes.

Llewellyn (1998a) discusses the re-negotiation of managerial/professional relations in the social services. Through this re-structuring, professional “front line” social workers were

⁵ However, it should be noted that to the extent that GPs suggested to patients that they may wish to pay privately for hospital treatment a degree of financial reward continued to be conferred on consultants by GPs after 1948.

required to assume managerial skills. Greater professional engagement with managerialist agendas resulted. For example, social workers began to view “contracting” in a more positive light as they perceived that this management tool could result in benefits for their clients.

Llewellyn, 1998b looks at how the concept of “financial responsibility” is ascribed to social workers from managers in the social services. This paper shows both more professional engagement with issues concerning resource consumption (for example, a greater degree of willingness to purchase private sector facilities where these are cheaper) but, also, a degree of “shoring up” of professional operational boundaries around social work activities as resource pressures increase.

Llewellyn, 1999 focuses particularly on the managerial techniques transferred to clinical directors from management and on the differences between surgeons and physicians in this regard. The paper demonstrates the differential engagement with management techniques as surgeons adopt more corporate attitudes and show a greater willingness to standardize and regulate their clinical practices.

Fujimura (1988, 1992) is concerned with resource flows. In a related field of work Star and Griesemer (1989) introduced the concept of a boundary object. A boundary object inhabits intersecting social worlds and satisfies the information requirements of each of them; coherence across social worlds is developed through the creation and maintenance of boundary objects (see discussion in Star and Griesemer, 1989, p.393). Once in place, boundary objects manage the tension between divergent viewpoints through being plastic enough to adapt to local informational needs whilst being robust enough to create commonalities. Boundary objects may have rather different meanings across social worlds but their structure is common enough for them to function as a means of translation, co-operation and integration (see Bowker and Star, 1999, p.292-7). Star and Griesemer (1989) distinguish four different types of boundary object: repositories; ideal types; coincident boundaries; and standardised forms. This last category is of the most relevance to this thesis as standardised forms allow for common communication, can travel over long distances and convey unchanging information. Budgets can be considered as the standardised form of boundary object; they represent financial resource flows in quantitative informational terms and, once devolved, they relate to both professional and managerial social worlds. The devolution of budgets from managers to professionals is the central concern of three of the empirical papers in this thesis. *Llewellyn, 1997* demonstrates how various forms of co-operation between consultants and GPs increased through the medium of fundholding. *Llewellyn, 1998a* focuses on the impact of budget- holding on care managers and how this role increases the integration

between “costing” and “caring” as entry points (Amariglio *et al*, 1993) to the domains of managerialism and professionalism. *Llewellyn, 1998b* explores the reactions of front line social workers to budgetary responsibilities in terms of the translation of professional functions involved.

Foucault’s work draws attention to the various “conditions of possibility” (1980, p.243) inherent in different social worlds. The multiplicity of political, social, institutional, technical and theoretical concerns in any domain fosters environments that are heterogeneous with respect to boundary work. Consideration of the very varied “conditions of possibility” within different forms of professional work points to the achievement of very varied forms of integration with managerialism. The empirical sections that follow outline the differences both within medicine itself and between medicine and social work in terms of a more direct engagement with management agendas. One key overarching difference between medicine and social work that relates to Foucault’s writing is the greater power/knowledge invested in medicine due to bio-power (see Rabinow, 1984, pp.257-289). Clinical power to “...qualify, measure, appraise, and hierarchize...” (Rabinow, 1984, p.266) in the regulation of the living greatly exceeds that of social work power. Although both health and social work derive power through their concern with therapeutic change in the pursuit of the well-being of the population, the closer engagement of medicine with the “Right of death and power over life” (Rabinow, 1984, pp 258-272) protects the clinical domain to a greater extent than the social work domain from unwelcome managerialist encroachment. Within the clinical realm itself the very varied power/knowledge intersections in medicine (as opposed to surgery) have led to very different terms of engagement with management (see *Llewellyn, 1999*).

The terms of engagement between medicine and social work on the one hand and management on the other are negotiated through boundary work. Both medicine and social work, as disciplines, have routinely employed boundary work to enlarge (if possible) their area of expertise, to distinguish their knowledge from that of other disciplines through the demarcation of territory and to adjudicate claims to solve societal problems from rival practitioners. Boundary work achieves the unity of a discipline (see Gieryn, 1983, for a discussion of the issues of expansion, monopolization and protection in the context of the demarcation of science from “non-science”). In this thesis, these issues are also relevant but the central focus is on boundary work as a mode of achieving some merger between the (previously) separate disciplines of management and professionalism.

One way of thinking about what has kept managerialism and professionalism apart is to use the idea of an entry point. As argued earlier, “caring” has been the entry point for the

therapeutic professions of medicine and social work, whereas “costing” forms the entry point to managerialism.

Boundaries serve two purposes. First, they act so as to differentiate mutually-defining discourses (Cooper, 1990). Second, they shape domains through regulating the types of difference permitted within them (Messer-Davidow *et al*, 1993). Boundary work and entry points (Amariglio *et al*, 1993) are mutually implicated as entry points constitute the ultimate discriminators between activities that are thought to be intrinsic or extrinsic to particular discourses. “Caring” distinguishes what is or is not appropriate to professional therapeutic practice, whilst “costing” serves as a focus for managerial activity.

Professional resistance to managerialism is articulated primarily through discourses that posit the antithetical nature of “costing” and “caring” (Llewellyn, 1997; 1998a; 1998b; 1999). In this way, boundary work protects the “entry points” to professionalism and managerialism. Instances of this defensive boundary work are explicated in Llewellyn, 1998a as social workers seek to maintain “fixed price contracting” as a shield against the encroachment of “costing” and in Llewellyn, 1998b as front line social workers attempt to pass their costing responsibilities “back up the line”.

In turn, whenever professionals can see instances of “costing” enhancing “caring”, the elaboration and constitution of these concepts changes. For example, in Llewellyn, 1998a (p.37) when “costing” was defined as possibly enabling the “freeing up of more resources”, boundary work to align “costing” with “caring” began. And in Llewellyn, 1998a, 1998b pockets of receptivity towards managerialism began to form through shifting boundaries, as social workers perceived that desirable forms of professional accountability were being promoted through “costing”.

As argued above, boundary work occurs whenever connections are perceived between the entry points to particular disciplines but it also proceeds, in defensive ways, in order to protect cherished professional practices encoded in “entry points” (Amariglio *et al*, 1993). However the primary site of boundary work, in knowledge terms, is, as the metaphor indicates, at the boundary of a discipline. Weakly classified, impure knowledge sits at the boundary of a discipline (Johnston, 1978). In contrast, research-based theory and technique occupies a high, hard ground at the centre of a discipline (Schön, 1988, p.67). The centre of any discipline is a territory where problems can be settled purely on terms dictated by the discipline itself, whereas, at the boundary, interdisciplinary knowledge has an impact (Douglas, 1982, p.174). “Boundary- type” of knowledge makes for instability or permeability (Klein, 1993), with

respect to the discipline of which it forms a marginal part. In consequence, whenever professionals assume managerial work they risk ostracism from colleagues, as they are perceived as engaging in “impure” or “soft” work. As Douglas (1982, p.174) points out, “Around this centre [of the discipline concerned] the most forceful exponents find it most worthwhile to cluster. The fringes are for the fringy. Thus a centripetal force in the institutional framework of knowledge exerts a magnetism for talent, time and funds.” At the same time these “fringy” boundary roles constitute a prime site for integration between management and professionalism (*Llewellyn, 1998a; Llewellyn, 2001a*).

Several authors in the tradition of the sociology of the professions are also concerned with the “doing” of boundary work. Abbott (1988) uses the central concept of jurisdiction to theorize the boundaries that internally differentiate the professions. Both interprofessional and intraprofessional boundary disputes are discussed in this work. *Llewellyn, 1997* draws on this work to understand professional regression, client and work differentiation and career progression. Brunsson (1989, 1990, 1994) is centrally concerned with the assignment of responsibilities as a way of re-negotiating the boundaries of professional work. *Llewellyn, 1998b* uses this literature to theorize the ascription of financial responsibilities in the social services. Gieryn (1983) considers the shifting boundaries of forms of expertise in professional work. In *Llewellyn, 1998a* this theoretical perspective underpins an understanding of the encroachment of managerialism on social work practice. The next section (“The case for integrating expert labour through boundary work”) continues to elucidate the links between “boundary work” and the literature on the sociology of the professions through a specific focus on the concept of expertise.

Moreover, “boundary work” as a theoretical concept articulates more closely with a hermeneutic methodology- as the latter rests on the “double hermeneutic” between first and second order constructs. As boundary work, as a concept, remains close to the empirical conditions it seeks to explicate (first order constructs) whilst still being able to encompass second order constructs (or social products), it synthesizes well with hermeneutics. As respondents articulated their engagement with boundary work at interview, the first order constructs of hermeneutics capture and synthesise their “micro” experiences. Grand narratives take a more abstract turn; being concerned with “macro” phenomena and long time/space distanciations and, hence, with second order constructs (or social products) rather than first order ones. The following sections expand on boundary work in public services.

The case for integrating expert labour through boundary work

Several authors have argued that as post-industrial society becomes increasingly dependent on knowledge workers, the management of expert labour becomes the key critical issue in contemporary organizations (see, for example, Bell, 1973; Dreyfus, 1979; Crompton, 1992; Gibbons et al, 1994; Giddens, 1994a; Scarbrough, 1995). Experts produce and communicate knowledge. Expert knowledge or expertise has superseded capital as the foundation of the socioeconomic order (Burrell, 1995). Expertise is distinguished from other forms of work by its close connections with both knowledge generation and power configurations.

Knowledge, expertise, professionals and managers

Knowledge legitimizes action (Stehr, 1994). Expertise has an economic scarcity value⁶. Both of these attributes are mobilised by experts to take (and maintain) power in organizations (Fischer, 1990). Expertise links closely to power and is, therefore, is simultaneously a stimulant and a barrier to change, innovation and progress in organizations (Starbuck, 1992). Managing expertise is not just about exploiting its competitive advantages but circumventing its barriers to change (Scarbrough, 1995, p.4). The management of expertise must negotiate expertise-knowledge-power linkages.

Historically, knowledge-based occupations were synonymous with a professional and scientific model of work, but this is no longer the case. The examples of management consultancy, IT, and financial services demonstrate that expertise is both wider (and more applied) than traditional, professional knowledge based in science. Expertise is “knowledge in the world” not “knowledge of the world” (Scarbrough, 1995, p.3). The concept of “expertise” as “knowledge in the world” links professionals and managers in a way that the idea of “scientific knowledge” does not. As discussed in the introduction, in this thesis both practising professionals and managerial professionals are regarded as different types of expert. This understanding breaks with the influential distinction between professionals and bureaucrats (introduced by Talcott Parsons⁷). Amongst other asserted differences, Parsons uniquely tied the notion of expertise to the ‘professions’⁸. In this thesis, managers are also conceptualized as possessing expertise, for example, in administration, control,

⁶ This scarcity value diminishes if the expertise becomes “over-supplied” in the labour market or if the “expertise” in question becomes more easily acquired.

⁷ Parson’s work was subsequently extended by the functional theories of Greenwood (1957), Wilensky (1964) and Merton (1982).

⁸ The Parsonian conceptualization of the ‘professions’ distinguished them from ‘bureaucrats’ through arguments about the technical rationality of their expertise, the ethical nature of their practice and the legitimated (by society) basis of their authority.

communication, human resources and budgeting. Practising professionals and managerial professionals in public services are similar in other significant ways. Both of the professional and management groups considered here work within complex organizations, so the professions are bureau-professions (Mintzberg, 1993) rather than free-standing associations. Moreover both professionals and managers manage resources on behalf of others and are, therefore, engaged in agency relationships (Armstrong, 1989).

The disengagement between professionals and managers

Despite these continuities, traditionally, there has been disengagement between professionals and managers in the public sector. Currently, the terms of this disengagement are being re-negotiated; the empirical research underpinning this thesis focuses on the shifting and transitional nature of the division between practising professionals and managerial professionals (as experts in the public sector) as they go about generating, controlling and applying their expertise. Abbott (1988) uses the central concept of jurisdiction to understand how different occupations defend the control and application of their expertise from outsiders. Sequences of jurisdictional control occur and jurisdictional boundaries come under attack as expert groups seek to acquire the knowledge and skills of others whilst retaining a monopoly on their own (Armstrong, 1984, 1985; Llewellyn, 1997, 1998a, 1998b, 1999). Prior to the struggles illustrated in the empirical papers in this thesis a *modus operandi* (see below) had been established between professionals and managers. This concordat ceded some special privileges to organizational professionals. Raelin (1985) lists four such rights: discretion over the parameters of professional work; the freedom to question management's decisions over professional activities; a reliance on professional norms of evaluation; and the right to engage in professional activities whether or not these were in the best interests of the organization.

The disengagement between practising professionals and managerial professionals in the public sector has a complex background. First, historically the public sector was administered rather than managed. Public sector administrators pre- the 1980s were more akin to diplomats than to active managers who shaped the direction of services (Greenwood and Stewart, 1986; Ackroyd et al, 1989; Clarke et al, 1994; Harrison and Pollitt, 1994; Grey and Jenkins, 1997). The public sector was governed largely by professional autonomy, expressed through paternalism and technocratic rationalism (Klein, 1995, Llewellyn, 2001a). For example in UK health care, paternalism dictated that it was, "...the doctor's judgement which would determine who should get what." (Klein, 1995, p246).

Technocratic rationalism underpinned paternalism by putting, "...problem solving through expertise..." (Klein, 1995, p.95) at the heart of NHS decision-making. The example of senior

clinicians in health care illustrates Scarbrough's (1995) argument on how, "Expertise may be sustained by its recursive relationships between a group's control of techniques and its strategic position in decision-making processes." (p.29). Outcomes in the public sector were the aggregate result of the decisions made by individual professional practitioners rather than planned in accordance with management's organizational strategies (Llewellyn and Tappin, 2001).

Second, the tasks, attitudes and values of professionals and managers were frequently at variance. Public sector managers held to administrative values of efficiency, fairness, honesty and adaptability (Hood and Jackson, 1991). Public sector professionals espoused the values of planning, meeting needs, trust and stability (Klein, 1995). As, traditionally, the professionals controlled the ethos and direction of public services, "custodial management" (Ackroyd et al, 1989) prevailed.

Third, practising professionals and managerial professionals operated with different criteria for the assessment of public sector work. Practising professionals see the value of their work in terms of the quality of inputs and the process of service delivery, whilst managers assess outputs and value for money. Practising professionals and managerial professionals judged each other to be different (see *Llewellyn, 1997; 1998a; 1998b*).

The potential for integration to bring a greater effectiveness to public services

Although these differences create barriers to greater integration between professionals and managers, there is now a substantial volume of research that points to the greater effectiveness of public services when practising professionals and managerial professionals work jointly within them (Scott, 1985; Young and Saltman, 1985; Abernethy and Stoelwinder, 1990; Shortell et al, 1990). There are a number of reasons for this.

First, although the direction of public services has been the result of decisions made by individual professionals (see below), practising professionals lack strategic management decisions made in the context of their one-to-one relationship with clients/patients, they have not considered how the aggregate result of these decisions shaped the overall service offered. Professional work has been directed at "micro" care, which is governed by the needs of individual patients/clients, rather than "macro" care, which assesses the health care characteristics of populations and organises to meet these requirements (Scott, 1982). For example, in the NHS in the 1970s when there was some additional financial resource available, doctors used this to treat patients more intensively rather than to treat more patients (Harrison and Pollitt, 1994). There had been no "strategic" intent to concentrate resources on

patients already “in the system” (and allow waiting lists to build up) but this was the result of individualised professional decision-making. Some integration between professional and managerial expertise potentially provides a strategic overview of the way that services are (or should be) developing and helps ensure that any agreed strategic initiatives are successfully implemented.

Second, there is an increasing requirement for active management in the public sector as services become more complex (Scott, 1985). In health care, for example, technology has exploded, medical specialities have sub-divided, consumer expectations have risen, the significance of risk management has greatly increased, mandatory requirements to produce unit costs have been implemented, purchasing (or latterly, commissioning) has been introduced and governments have emphasised partnerships with other agencies (in particular public-private linkages). In order to track and monitor this increasing complexity, the information systems of public services have greatly increased in sophistication, and, consequently, these systems now present a challenge to effective organizing in the public sector (Bloomfield, 1995). In this context, there is an ever-widening gap between what the practising professionals can deliver in terms of co-ordination, control and performance measurement and what stakeholders expect (Townley, 1996). Even from the internal point of view of the public sector professions themselves, more management expertise is called for.

Third, ideas on the production and use of expertise are changing. Gibbons et al (1994) argue that the predominant traditional view of knowledge was that it was accumulated (and assimilated) within disciplinary boundaries in universities. Such knowledge was then available (in the form of professionally bounded expertise) to be applied to practical problems. They then offer an alternative view: that expertise is produced in context, through combining different organizational groups to build on synergies and heterogeneity. In this way issues are addressed through generating and utilizing transdisciplinary knowledge. Other work supports this alternative view of knowledge. Schön (1991) presents the concept of “reflection-in-action”: knowledge that is developed through practice in order to cope with unique, conflicting and/or “messy” situations. Nonaka and Takeuchi, (1995) assert that all employees should operate as knowledge workers; inventing new knowledge should not be thought of as a specialised activity. Spender (1992) argues that “communities-in-practice” (p.412) produce knowledge through emergent processes. Frohman (1997) emphasises that new knowledge is generated through the achievement of organizational change and how new knowledge is essential to such change.

If this “in situ” view of knowledge has increasing relevance, then integrating across the diversity of professional and managerial knowledges in public services has a potential for addressing pressing public sector problems. The issues (identified above) of strategic direction, aggregate delivery, technological advance (in the context of resource constraints), risk management, rising consumer expectations and public–private partnerships require a “knowledge in the world” approach. Creating expertise that overlaps professional and managerial work is a key aspect of public sector management.

The next section explores the theoretical basis for deciding if the use of numbers, money and budgets has an integrative potential across the divide between managerial professionals and practising professionals.

Assessing the integrative power of budgets, money and numbers

Organizations (public sector institutions and private sector corporations) are now the means for societies to achieve their ends. All organizations use money, along with knowledge, as fundamental resources. It is in the context of organizational forms that money as an integrative resource has a particular significance, as organizations exist to co-ordinate the many and diverse talents of individuals. Cooper (1990, p. 172) defines organization as “...a structure that relates people to each other in the general process of managing nature and themselves.” Child (1984) pinpoints the basic structure of organization as achieving, “...the successful implementation of plans by formally allocating people and resources to the tasks which have to be done, and by providing mechanisms for their co-ordination.” The way that money is distributed to resource organizational activities can either co-ordinate or, alternatively, differentiate organizational activities.

In private sector organizations the “bottom line” of profitability drives activities and provides an integrating focus. Numbers are integral: accounting makes sense of all private sector organizational resources and outputs in monetary terms. *Llewellyn (1994)* argues that accounting casts money into numbers that signify order within organizations. These accounting numbers integrate through binding organizational space/time in representations such as profit and loss accounts, balance sheets and internal management accounting reports. In this way accounting numbers represent the basic organizational realities of profit, loss, asset and liability; they are also implicated in “... organizational histories, systems of accountability, moral codes and temporal ordering...” (*Llewellyn, 1994, p.16*). All of these representational forms enable greater integration across organizational sub-units.

Cooper (1990) points out, "...that representation is a necessary part of the 'knowing' process." (p. 169). The world is not directly knowable; the world is experienced through representations (Sayer, 1992, pp. 45-84.). Yet the very familiarity of representations fosters a "forgetting" of the representational act. There is a tendency to assume that representations allow unmediated access to the world- and therein lies their power. The signs and symbols of accounting are the most significant financial representations of the organizational world; they are also representations that tend to promote the power and influence of those in management roles. Douglas (1982 p.37) argues that once a representation is accepted from the flux of possible forms, this particular representation clarifies and fixes knowledge of the external "reality". In this way accounting numbers construct the organizational "realities" of profit, loss, asset and liability, frequently privileging managerial interests over those of other stakeholders. Acceptance of these (potentially contestable) accounting constructions across organizational sub-units integrates as different activities/functions are dealing with a common financial "reality". There is a common "forgetting" of the representational role of accounting as organizational actors come to see accounting as the financial "real thing" that they have to pay attention to.

Public sector organizations are different to private sector entities with respect to money as a resource. In the public sector the provision of services is divorced from payments for services provided. Money to resource activities comes from central government via the tax system. Breaking the link between payment and provision has a number of consequences. First, there is no on-going adjustment to the supply of services consequent upon fluctuations in revenue from consumers. There are no incentives for providers to cut back on supply; indeed supply-induced demand is a feature of the public sector (Harrison and Pollitt, 1994). Equally, as consumers pay collectively in amounts that are not dependent on services received, there are no incentives for consumers to limit demands. Second, without a focus on profitability, there can be much more scope for the aspirations and career goals of providers to drive the content of services (Champagne et al, 1997). Third, in the absence of signals from a market, central government is reliant on signals from providers to make decisions on resource allocation (Nutt and Backoff, 1992).

When public sector providers solicit resources they put a case on the basis of poor results rather than good performances, by arguing that needs are not being satisfied or that quality is not high enough (Brunsson, 1994). For example, doctors have tended to argue their case for more money through "shroud waving" (Harrison and Pollitt, 1994). Advocacy based on worst case scenarios for clients/patients (unless more money is forthcoming) has been the traditional mode of resource acquisition in the public sector (Llewellyn, 1999). This is significantly

different from the stance of private sector companies who acquire money from their financiers (the consumers) by attempting to convince them that they have a high quality product or service to offer.⁹ Overall, third party payment for public services results in a system with few incentives for limiting supply or demand and, hence, produces escalating pressures on resources¹⁰. Signals from providers, rather than consumers, direct resource allocation and it is difficult for governments to know how to act on the basis of such signals, as they are ambiguous. Policy-makers in the public sector lack knowledge of “allocative efficiency”, in the sense of ensuring that resources flow to those who can make best use of them (*Llewellyn, 1999*).

Private sector organizations are not immune from these influences, as knowledge becomes the key competitive resource; private sector organizations are seeking to further integrate their activities through the use of money. Project-based budgeting, for example, funds organizational outputs rather than inputs and seeks to mitigate the myopia of functional groups through cross-boundary budgeting (*Llewellyn, 2000*).

The financial impact of decisions taken by public sector providers is not obvious to them (tracing such an impact may often be problematic in the private sector but there are some indicative mechanisms (e.g. divisional budgets, project appraisal and rates of return)). Global aggregate budgets have been the norm in the public sector; these give little indication of the resource consequences of actions and are not well suited to financial control. In some cases actions consequent on decisions taken in one area of the public sector are actually funded in another. For example, prior to the transfer of the budget for residential care to the social services, clients entering residential care were funded by social security (*Llewellyn, 1998b*). This situation gave rise to a “perverse incentive” (*Wagner, 1988*) for social services to make placements in residential care rather than supporting clients at home as the cost of residential care was met by social security whereas community care was funded by social services.

Where monetary exchanges take place to resource activities, the source, direction and flow of the money are significant determinants for which activities are resourced and on how resourced activities are conducted. Money, as a resource, also integrates (or differentiates) work activities. Where areas of expertise are jointly funded, participants must work together to determine how the money is used. But if different occupational groups receive separate

⁹ There is, of course, no judgement being made here that the quality of goods and services is lower in the public sector than the private, merely that modes of argument to obtain resources in the public sector have been based on under-achievement.

¹⁰ Arguments about whether or not the public sector is under-funded (as a whole or in part) constitute a very important policy debate. But this debate is beyond the scope of this paper which concentrates on the issue of resource allocation within the global budget set by government.

allocations of money there is no financial incentive for them to co-operate. Where one group makes decisions that are funded by another, perverse incentives are likely to arise. If the groups concerned are already diverse in terms of interests then conflict may ensue and the lack of financial incentives to co-operate is even more telling.

Budgets offer quantification of the financial consequences of plans of action. So action plans consequent upon different value judgements can be assessed through budgets. Budgets are also financial limits so they evidence the action feasibility of value judgements; budgets dictate “what’s do-able”. Where one professional group holds a budget to purchase services from another, the former group can exert some leverage over the latter in terms of the services delivered. Knowledge of this leverage relationship opens up dialogue between the two parties, (as was the case when GP fundholders re-established links with their colleagues in the hospitals (*Llewellyn, 1997*)). Monetary exchanges can be “channels of communication” (*Ezzamel and Willmott, 1993, Llewellyn, 1997*).

Budgets are particularly powerful instances of the integrative potential of both numbers and money. The integrative potential of budgets relies on a principle that applies to both numbers and money, “...things shall be put together.” (*Bernstein, 1971*). Numbers are intimately linked to the concept of rationality. The word “rational” is derived from the Latin *ratio*: a reckoning (*Morgan, 1965, p.32*). Rationality began to replace tradition as a basis for the legitimization of practice during the 19th century (*Abbott, 1988, p.190*). Theorists, such as Weber, predicted an inevitable trajectory of rationalization and disenchantment for the modern world. Such a disenchanted world provides a context where the reassurance derived from calculability can potentially replace the sanctity of ultimate values (*Power, 1992; Llewellyn, 1994*). From a Weberian viewpoint, faith in the ultimate value of rationality began to erode other value perspectives. A belief in the ultimate value of rationality enables a context where numbers can begin to integrate dissimilar domains.

Porter (1998) offers a somewhat different picture on the integrative power of numbers. He describes how rationalization (through quantification) rather than eroding other values, renders them compatible, ‘...numbers are the medium through which dissimilar desires, needs, and expectations are somehow made commensurable.’ (p.86). Numbers are effective integrators as they summarise complex events in familiar, reassuring and standardized forms. By providing measurability, numbers constitute standards through which the actions dictated by different value positions can be assessed. Numbers are “strategies of communication” (*Porter, 1998, p.viii*) and provide conduits through which different discourses flow. Clegg (1990) points out that people make sense of the projects on which they embark in terms of the

“forms of calculation” (p.7) they have available to them. Numbers reduce, absorb and/or deny the uncertainty that attaches to human values (and the projects these values give rise to). In all of these ways, the trust and security that numbers can enable may begin to link dissimilar “communities of knowing” (Boland and Tenkasi, 1995) or “social worlds” (Star and Griesemer, 1989; Bowker and Star, 1999).

Numbers allow for a system of counting. From the earliest times man counted his possessions to establish his status within his social group (Morgan, 1965, p.32). But ‘number’, as a purely abstract concept, is not acceptable as a standard of value. In contrast, “Money measures not only itself, but almost anything else which can be quantified. Money, in its broadest definition, is the means for comparing –in quantitative terms- two unlike things on a scale which is common to both of them.” (Crump, 1990, p.92).

It was not until the advent of money that incontrovertible comparisons between the wealth of persons with dissimilar possessions could be made¹¹. Nor could satisfactory exchanges between dissimilar things take place until money provided a common currency. Money was an essential prerequisite for the move from subsistence production to specialization and the division of labour (Morgan, 1965, p.11). As money provides a common denominator that reifies value in terms of recognised units (Crump, 1990), money can support highly differentiated forms of social relations. As Douglas (1982, p.58) points out, “...money in its nature is essentially an instrument of freedom...[and]...it represents the opening of opportunities.”

Money is a social phenomenon. Yet questions on the meaning of money in society have tended to be subsumed within the discipline of economics (Frankel, 1977; Simmel, 1978; Bretton, 1980). Neo-classical economics regards money as a purely functional mechanism that acts as a medium of exchange, a store of value and a unit of account. Within this framework, questions of the sociology (or philosophy) of money are not facilitated. In a neglect of the non-economic aspects of money, “...the opportunity to uncover, isolate, and analyse the social roles, functions, purposes, and effects of a vital, if not the most vital, ingredient of our social existence...”. (Bretton, 1980, p.xiv) is lost.

In so far as the impact of money on social relations was considered within the economic paradigm its effects were seen as individualizing (Frankel, 1977, p.17-29.). Influential sociologists who did touch upon the impact of money on social relations also thought

¹¹ Before money, cattle were used as a standard article for the purposes of exchange. The word “pecuniary” is derived from *pecunia*, the Latin for money, which came from *pecus*, the word for cattle.

individualization to be the result of monetary exchange. For Marx, the crisis of alienation within society could be ascribed to the increasing abstraction of relationships under commodity exchange expressed in terms of money. In *Capital* Marx contrasted the alienation of labour under abstract capitalist economic conditions, governed through money, with the concrete and natural social relations that prevailed in pre-capitalist times, when production was for direct use. Habermas made a conceptual distinction between the “lifeworld” of human values and the “system world” of work; money and power operate as “steering mechanisms” in the latter while communicative interaction is the “steering mechanism” in the former. In believing that exchange through money inhibits the communicative interaction that supports human values (and moral codes) Habermas is similar to Marx. Opinions concur that exchange facilitated by money is a “silent trade¹²” (Morgan, 1965, p.9).

However if the focus on money as a medium of exchange broadens out to a consideration of the wider social function of money, other ways of thinking about money emerge. Marx commented on money’s, “....socially validated monopoly of equivalence...[as]...it preserves and reproduces itself incessantly in its distinct form.” (de Brunhoff, 1973, p.23). This formulation opens the way for theories of the social impact of money¹³. In this respect, the work of Georg Simmel was an exception to the dominant 19th and 20th century thinking that linked money exclusively with individualization, alienation and non-communication. As he feared the undermining of moral behaviour through the pursuit of money, Simmel was concerned to draw out the implications of monetary order for human morality (Frankel, 1977, p.5). Simmel emphasised the ways in which social relations are expressed through symbolic images. As society develops, the immediacy of interacting forces between individuals is partially replaced by “...higher supra-individual formations, which appear as independent representations of these [sic] forces and absorb and mediate the relations between individuals. These formations exist in great variety; as tangible realities and as mere ideas and products of the imagination; as complex organizations and as individual existences.” (Simmel, 1978, p.174). Examples of such reified social functions are: how the law is embodied in the judiciary; how the unity of a military regiment is incarnated in its flag; and how the function of exchange becomes crystallized in money as an independent structure. For Simmel, money was an extremely potent symbol that expressed images of unity and interdependence in social relations.

¹² Morgan (1965) describes very early forms of trade where not only was there no conversation but there was not even direct contact between the traders. Members of a family (or tribe) would set the goods that they wished to dispose of and then retreat and not return until the other parties to the bargain had displayed what they were willing to offer in return and retreated in their turn.

Anthropologists introduced the concept of “reciprocal recognition” (Gregory, 1997) as a counterbalance to “individual cognition”. The reciprocal recognition of money as a standard of value links relations between things to relations between people (Gregory, 1997, p.12). The circulation of money depends upon the principle of reciprocity (although there is no need for two reciprocal benefits to be coincident at a point in time). The constant flow of benefits maintains (and is maintained by) a network of reciprocal obligations; the circulation of money and the prevailing social relations are mutually implicated and supportive (Crump, 1990). As Hart (2000) puts it, “...the pursuit of its [money’s] objective foundation is illusory. Money is a measure of social interaction, no more, no less. We make it up, although most people prefer to think of it as already made. Above all, the consequences of examining what money really is are so shocking (because more metaphysical than physical) that the world, prefers, for the most part, not to think about it...We have only recently discovered the idea of ‘virtual reality’, but in the world of money we have been living with nothing else for a long time.” (p.245; p.253). Because money is something that we “make up” through social interaction, the relationship between money and trust is a complex one.

Martin (1999) argues that money, “...allows- indeed provides a mechanism for- the simultaneous ‘stretching’ and ‘compression’ of social interaction across time and space...”. Money symbolizes both formlessness and centrality¹⁴. As formlessness, it circulates as a liquid medium that, lacking internal limits, has effects that are simultaneously both far-reaching and reductionist (Simmel, 1978, p.495). Douglas (1982) points out that, “It is in the nature of money to flow freely, to be like water, to permeate.” Money must be able to circulate indefinitely across the span of people who are using it (Crump, 1990, p. 95). As centrality, money is a “stable pole” (Simmel, 1978, p.121) that sublimates the relativity of all other things. People can “...take comfort from money’s symbolic steadiness.” (Hart, 2000, p.264). Through this societally established form of trust, money makes possible an ever-widening span of interdependence amongst people. This interdependence is fostered as trust in money reduces social complexity. Money, just as power and truth, functions as a communicative device that economizes on information; the “liquidity” of money rests upon both certainty (or centrality) and equivalence (or formlessness) (Frankel, 1977, p.38).

Trust in money also fosters integration, “Money blurs the edges of ideas, of groups, of personalities.” (Bretton, 1980, p.xxvi). In a barter economy, transactions are dependent upon the social relationship between two people and require a co-incidence of “wants” at the same

¹³ Although Marx understood money as a social force, the intent of *Capital* was to expose the way that money is organized to exploit working people (Hart, 2000, p.266)

¹⁴ This is reflected in our metaphors about money e.g money makes the world go around and money is the root of all evil.

moment in time. But, in a money economy, the whole society guarantees the functioning and acceptability of the money the two parties utilise. Exchanges are freed from the constraints of transitory individual needs. A monetary transaction takes place through a promise underwritten by a society. This promise recalls money's function as a means of keeping track of our exchanges with others-as a way of remembering. Hart (2000) points out that money and language are the primary cultural infrastructures that allow people to communicate with each other, "Communities share meanings by means of markets and conversation, through objective and subjective exchange." (p.321).

Simmel recognised how money comes to embody the potentiality of power, as it is, "...the most certain, and most powerful, means of attaining not only known or immediate ends chosen by the individual but also the most remote: even the as yet unformulated desires which he might conceive." (Frankel, 1977, p.13). But, the paradox at the heart of the power of money is that it is nothing outside of the objects, services or rights to which it gives access. It is argued here that Simmel's analysis of money (as interdependence and power) is basic to present day thinking of money as a *resource*. When money is used as a resource to accomplish valued ends the metaphorical associations of individualization, alienation and non-communication are not always helpful. Money as a (re)source can be a source of integration.

Having considered the potential for budgets to accomplish boundary work through exploring some theoretical material on the integrative power of numbers and money, and the role of numbers in establishing trust, this critical review now moves to look at the empirical work of the thesis.

COMPARATIVE EMPIRICAL FINDINGS

This section focuses on the four empirical papers- *Llewellyn, 1997, 1998a, 1998b and 1999*. Before discussing the contribution of these papers to boundary work, the methodology that underlies the research projects on which the papers rely is described.

Methodology

The methods employed in all four of the empirical papers were qualitative and relied on semi-structured interviews, supplemented by documentary sources (see specific papers for further

details). Interviews (rather than, for example, focus groups) were conducted as the empirical papers present the “strategising” (Barry and Elmes, 1997) of the professionals concerned. It was thought that individuals would be more likely to reveal this strategising in one-to-one interviews rather than in the more open and public forum of a focus group. In presenting the empirical findings, the papers use narrative accounts (see Llewellyn, 1999) for an exposition of narratives in management and accounting research). The methodology underlying these methods is set out in *Llewellyn, 1993*. Key aspects of this methodology (along with illustrations of its use in the empirical papers) are discussed in this section.

Llewellyn (1993) draws some linkages between hermeneutics and interpretative research in management. Hermeneutics locates social action as a text-analogue i.e. the understanding of social action is analogous to textual interpretation. This understanding is based upon four areas of congruence between *verstehen* in the social sciences and textual interpretation. In *Llewellyn, 1993* these areas are summarised as four hermeneutic propositions:

Proposition One: The ‘sense-content’ of action and text must be drawn out; comprehension cannot be immediate or unmediated.

Proposition Two: The text or the action has both personal and social significance, its social dimension implying the possibility of institutionalization.

Proposition Three: The text or the action may transcend its encompassment within its initial circumstances and develop meanings in other social contexts.

Proposition Four: Textual interpretation and social understanding are both essentially ‘open’ in nature.

That these propositions are basic to the hermeneutic endeavour can be seen by locating them within Giddens’ notion of the ‘double hermeneutic’ (1976, p.162; 1982, p.11; 1984b, p.284). The researcher encounters in the social world a realm that is already meaningful to the agents involved. Agents’ interpretations have been accomplished by reference to their own values and beliefs and by what they perceive as the ‘contextuality’ of their action. ‘Contextuality’ is here equated with the ‘setting’ of the action and defines the agents’ awareness of the processes and structures that they use to orient and make sense of their action (Giddens 1987, p.215). Thus Proposition One implies that the ‘sense-content’ of social action must be explicated through these first-order constructs (Giddens 1984b, p.284) but is not restricted to such constructs. That the ‘sense-content’ of action is not confined to agents’ own reasons, motives and values lies in its nature as a social product (Propositions Two and Three). Consequently researchers can construct ‘second-order constructs’ using their own ‘technical’ language which re-interpret the action, events and experiences of the researched (Proposition Two). However as human action is essentially an ‘open work’ (Proposition Four) the researched may choose to

appropriate the 'second order constructs' of the researchers. Hence these 'second-order constructs' may re-emerge as 'first-order constructs' presenting as fresh research material and so on.

These four hermeneutic propositions have implications for empirical research, *Llewellyn, 1993* summarises these as follows:

Implication One: Researchers can legitimately offer accounts of events which either differ from or transcend the understandings of agents themselves.

Implication Two: The research insights will be generated by the processes of projection and modification. They will reflect a synthesis of the frames of reference of the researcher and the researched

Implication Three: The interpretive research act is a creative endeavour whose inner coherence rests upon the starting point and boundaries which are imposed in the course of the research. Consequently the research findings will take the form of a narrative but this narrative is not constituted by a succession of episodes but constructs a meaningful totality from scattered events.

Implication Four- Hermeneutic research is intrinsically critical as, first, understanding must involve evaluation of actors' self-understanding and, second, actors may appropriate this evaluation and thereby change is enacted.

Some illustrations of these propositions and implications (along with examples of first and second order constructs) in the four empirical papers are given in Appendix 1.

In order to provide a context for the empirical findings on boundary work in the public sector it is necessary to give some comparative background on the NHS and social services. The next section covers this material.

Comparing the NHS with Social Services

This section compares the NHS with social services along three dimensions relevant to boundary work: the extent of professional autonomy; practitioner expertise and public esteem; and relative internal differentiation.

The extent of professional autonomy

Medicine is the archetypal strong profession (Schön, 1991) enjoying long history. Social work is a weak and, relatively, new profession (Jones, 1999; *Llewellyn, 1998*) built on a fragile base (Langan and Clarke, 1994). The welfare state embeds both bureaucracy and professionalism within all its organizations, but in the various settings across the public sector, the balance between the two elements is struck very differently (Newman and Clarke,

1994). In medicine, professionalism is dominant, in the social services bureaucracy holds sway. Social work is a state mediated profession (Johnson, 1972). In broad terms, social work practice is determined by legislation and Department of Health guidance. Moreover, social services form part of local government and professional practitioners are dependent on local counsellors working through political committees for resources. In contrast, clinicians operate autonomously (Harrison, 1999). Although they work to an overall budget set by central government, decisions on the allocation of money within the budget are purely professionally driven (Harrison and Pollitt, 1994; Klein, 1995).

The very different levels of autonomy in health and social services can be understood through the distinction between autonomy over ends and autonomy over means (Bailyn, 1985).

Autonomy over ends (or strategic autonomy) refers to the freedom to set organizational goals; in the public sector it also entails making decisions over the sorts of problem the service addresses. Autonomy over means implies the freedom to examine a problem, once it has been set, through whatever ways are deemed appropriate, given the resource and strategic constraints on the organization. Managers are more likely to be comfortable in ceding to professionals autonomy over means than they are autonomy over ends. In health, although clinicians have not had formal authority over the strategic direction of the NHS, in practice they have – as strategy for the NHS emerged out of the individual decisions made by senior clinicians (see above and Llewellyn and Tappin, 2001). For example, there was no explicit policy decision to de-prioritise the “Cinderella services” of mental health and geriatrics but, consequence on the relative powerlessness of the clinicians in these areas (and their associated inability to direct resources to their advantage), historically these specialisms became underfunded.

In the social services there is some autonomy over means but no autonomy over ends. The state determines (“ends”) through the constructions of the client “needs” that are to be served; it also mediates in the (“means”) in which these needs are met (*Llewellyn, 1998a*). Baritz (1960) termed social workers “servants of power”, reflecting their function as agents for governmental decision-making. In particular, social workers perform a control function for the state. They take children into “care”, commit individuals to mental hospitals and advise elderly persons to enter a “home”. These are all decisions that centre on the management of risk to the individuals concerned but also alleviate threats to the welfare of others (*Llewellyn, 1998a*). As Wilson (1993) points out, the therapeutic programmes offered in care centres obscures their other purposes as services that contain “difficult” people and diffuse discontent. Social workers make decisions that manage individuals who may cause social problems and, in this respect, social services serve the state.

These distinctions between autonomy over means and autonomy over ends in health and social services impact on the extent to which both organizations were rule-governed (and hence, responded through collective action) or were loosely-coupled collaborative systems (and, hence responded through individualized action). With limited individualized autonomy, the social services operates as a strong hierarchy with numerous prescriptive rules that enable collective action (Wildavsky, 1986, p.23). With a high degree of individual autonomy, clinicians in the health service have been, largely, free of prescriptive rules over their conduct and any collective action has been negotiated between individuals.

Practitioner expertise and public esteem

In part because of the circumstances discussed above, the professions are in receipt of very different levels of public esteem. Although, in recent times, there has been some diminution in the high public status of medicine, the general background to this has been one of unlimited trust (Leverment and Ackers, 2000). The NHS, as an institution, has been, and to a certain extent still is, sacrosanct- a great British icon symbolizing national pride and unity (Llewellyn, 1997). Social workers, in contrast, have been subject to public vilification (Langan and Clarke, 1994) and are, at best, generally seen as “brokers in lesser evils”(Stevenson, 1994, p.173). The risk management and control aspects to social work (e.g. taking children “into care” and committing people to psychiatric hospitals) do not tend to enhance the public worth of the services offered. The intrinsic value of the social services tends to be questioned by the public and the profession is, at best, tolerated- it is certainly not held in high regard (Llewellyn, 1998a).

Medicine is a male-dominated profession based on a strong epistemological structure through its grounding in science. Clinical expertise is fixed in the public mind as the outcome of a technical process mediated through judgement (Power, 1995). Social work practice is feminized (Abbott and Wallace, 1990) and, hence its professionalism is conceived in terms of the “power of nurturance” (Lorentzon, 1990). Nurturance implies “caring” but not “curing”; on a carer/curer continuum social workers strive to be seen by the public as carers and are certainly not viewed as curers. Whereas clinicians are firmly positioned as curers and, if occasionally seen as lacking in sufficient caring qualities, such attributes can be delegated to the nursing profession (and thus retained within the health arena (Walby et al, 1994).

Practitioners in the social services utilize tacit or experiential knowledge and they work in poorly defined situations (Llewellyn, 1998a). Social workers apply “know-how”. Such

knowledge does not exist in the abstract ready to be applied to a particular situation (Frankel, 1977, p.51) but must be fashioned at the time to meet the exigencies of the problem. Outcomes are unpredictable in social work in part because the active co-operation of the client is required for successful outcomes (Llewellyn, 1998a; Llewellyn and Saunders, 1998). In contrast, clinicians utilize scientific knowledge and through the skills of diagnosis, inference and treatment decompose illness into technical specialisms that do not differ much between patients and, hence can be treated by standardized remedies, irrespective of the patient's circumstances and history (Whitley, 1995).

Relative internal differentiation

Health care is characterized by tremendous internal differentiation. There is a remarkable variety of occupational groups involved in patient care (e.g. radiographers, midwives, occupational therapists, district nurses, dieticians, health visitors, physiotherapists and clinicians) each with their own view of the patient and the solution to the patient's problems (Mackay et al, 1995). Even within the ranks of the doctors there are marked internal divisions between, for example, junior doctors and consultants and hospital doctors and GPs. Honigsbaum (1979) commented on the hostile divide between hospital consultants and GPs (based in differences in workplace, tasks and career structure) that had developed since the inception of the NHS. Issues of philosophy, training and social attitudes create divisions not only between GPs and hospital clinicians but also within the hospitals between physicians and surgeons (Dingwall, 1995; Llewellyn 1997; Llewellyn, 1999).

The different practitioner groups in health care work independently and autonomously bounded by their own skills, experience and knowledge base (Mackay et al, 1995). Although the delivery of health care has been dominated by technical rationalism (Klein, 1995) other health care models are now becoming evident. Beattie (1991, 1993) argues that there are four competing "practice paradigms" in health care: the biotechnical model; the biographical model; the ecological model; and the communitarian model. These offer very various strategies of intervention in order to improve the health of patients (Beattie, 1995). The biotechnical approach focuses on rectifying health defects through biomedical science. The biographical model identifies problematic life events and offers coping strategies. The ecological model is concerned with environmental hazards and seeks social intervention to reduce risks. The communitarian model mobilizes social movements to share health concerns and campaign for change. The various occupational groups discussed above do not map unambiguously on to these models but there are clear linkages. Doctors remain committed to the biotechnical model but GPs, for example, tend to be more receptive to the biographical and the communitarian models than their hospital counterparts (see Llewellyn, 1997 and

Llewellyn and Grant, 1996 for comments from GPs on appropriate health care interventions). There are considerable professional tensions both within the ranks of clinicians (*Llewellyn, 1997*) and between the different health care professional groups (Walby et al, 1994).

In contrast to health care, the social services are much more homogenous. The work domain is structured into predominantly female “front-line workers” (*Llewellyn, 1998a*) and senior male management (Jones, 1999). Although there are tensions between these two groups (Jones, 1999), social work is not characterised by a multiplicity of different (and sometimes competing) practitioner groups and associated ideologies, as health care is.

These key differences (on autonomy, knowledge base, public esteem and internal differentiation) between health and social care have both mediated the ways in which managerialism has penetrated them and impacted on the boundary work between managers and professionals in the two domains.

Boundary work in the NHS and Social Services

Managerialism has penetrated health care and social work differently. Whilst both domains have been subject to new forms of financial control through devolved budgets, (see *Llewellyn, 1997; Llewellyn, 1998a; Llewellyn 1998b*) and a more generally constrained economic environment through quotas, targets and cash limits, (see *Llewellyn, 1997; Llewellyn, 1998a; Llewellyn 1998b; and Llewellyn, 1999*) the way that the reforms have been implemented has varied. Throughout the 1980s and early 1990s, health care was subject to the quasi-market and began to embody limited competition, whereas social services remained a monopolistic provider. In the NHS there has been considerable recruitment of private sector managers into senior management posts (*Llewellyn, 2001a*). Private sector staff have introduced a new set of value commitments and task orientations. But, in the social services, senior managers continue to be drawn almost exclusively from the social work profession (*Lawler and Hearn, 1997*). So if new values are to be generated they must come from a re-orientation in existing mind-sets. In terms of the institutional environment it can be argued that social work has been less “reformed” than health care. However, it could equally be asserted that, the impact of the reforms on work practices has been greater in social work than in health (see below). This section continues by discussing first, how the boundary between professional and managerial work is changing and second, the impact of boundary budgets in the two empirical areas under the three subsections introduced in the earlier comparative empirical sections.

The extent of professional autonomy

As discussed above, professional autonomy is greater in health care than in social work. This circumstance has impacted on the extent to which individual clinicians and social workers could evade (or embrace) devolved financial responsibilities. Fundholding, as a scheme, was optional within general practice (Llewellyn, 1997). Although the introduction of clinical directorates into health care was obligatory, assuming the boundary role of clinical director was voluntary (Llewellyn, 2001a). Doctors who became fundholders (or clinical directors¹⁵) did so because, either they had a particular interest in management and/or they anticipated power gains through devolved budgeting. Moreover, GP fundholders and clinical directors passed on routine operational management to other groups (generally, business managers and nurses, Llewellyn 1997; Llewellyn, 2001a). So although many doctor-managers did assume a “two-way” (Llewellyn, 2001a) orientation, core clinical practice remained insulated from managerialism. This insulation came about as, first, the majority of clinicians remain disengaged from management and, second, there were opportunities in health care to delegate the more mundane administrative component of managerialism. Perhaps even more significantly, social work was already much more bureaucratized than health care (see above) and, therefore, constituted a more receptive environment for management discourses. The impact of managerialism has been much more uniform in the social services than in health care and work practices have been transformed to a much greater extent.

All front-line social workers have been re-created as “care managers”. This change of title has brought with it a greatly increased administrative component to social work, with a corresponding decrease in opportunities to engage in therapeutic practice with clients (Llewellyn, 1998a). Although budgets may only have been devolved as far as team manager level and, thus, held away from the front line of service delivery (Llewellyn, 1998a; 1998b), all team managers have budgetary responsibilities. The boundary between managerialism and social work has become much more blurred than that between managerialism and clinical work.

Practitioner expertise and public esteem

In so far as “real” social work is equated with professional counselling expertise, increasing managerialism has marginalized this in favour of the control dimension of the social services (Llewellyn, 1998a; 1998b). There is more evidence, in the social services, of managerial tasks

¹⁵ As the role of clinical director was obligatory if there were no consultants with an active interest in management then the post tended to become filled by the most politically acceptable candidate to the clinical elite.

and knowledges being forced through to the heart of professional expertise itself (Scarbrough, 1995, p.41). And, in this process, there are more indications in the social services that the nature of professional work is changing. In social work, financial accountabilities and an awareness of cost constraints permeate the organization of work to a more uniform extent than they do in health care, where doctor-managers assume these responsibilities on behalf of their colleagues. This increasing managerialism in social work is consistent with a workforce that can no longer harbour, "...illusions about professional autonomy or ideals that service to the clients is paramount." (Jones, 1999, p.47).

The government proceeded more cautiously in health care in pushing managerialism through to the heart of professional expertise, in part because of the higher public esteem that health care enjoys. The strong epistemological structure of medicine, through its grounding in science, also militates against colonization by managers and managerialism. Although clinicians can take on managerial responsibilities, managers cannot assume clinical tasks (Llewellyn, 2001a). The scientific expertise of clinicians has proved more of a defence against integration with management than the "know-how" of social workers. Nevertheless, the advance of managerialism in both domains has had an effect on public perceptions on the nature of professional expertise, "This has lost some of its ethical and rhetorical baggage and has increasingly been marketed as a commodity" (Scarbrough, 1995, p.12). In the case of the social work this has resulted in changes at the "threshold" (Llewellyn, 1994) of the organization as the social services face a loss of work to the private and voluntary sectors (Llewellyn, 1998a).

Relative internal differentiation

The NHS is a highly internally differentiated organization (see above sections), offering many and various interstices through which managerialism can enter. This circumstance predicts that the impact of managerialism will be more varied within health care than in social services- as the latter is a more homogeneous environment. The evidence from the empirical research drawn upon for this thesis indicates that this is indeed the case. Within health care certain groups were enthusiastic about doing boundary work and integrating into a managerialist framework.

GP fundholders, for example, grasped the purchasing power that budgets conferred. Holding funds at the practice level allowed GPs to exert financial leverage over their hospital colleagues in three ways: using contracts to specify (to the advantage of GPs) processes of case management at the interface with the hospitals; using contracts to press for specific

quality standards in clinical practice within the hospitals; and using the financial flexibility of the devolved budget to “take back” into primary care certain clinical procedures that had been the sole province of secondary care (*Llewellyn, 1997*). A latent intra-professional conflict galvanised fundholding processes and GPs anticipated power gains through holding budgets. The boundary between general practice and management has always been more blurred than that between hospital clinical practice and management- as GPs have always run their surgeries and to this extent, have always engaged with a management agenda. Nevertheless, it is clear that many GPs seized upon the opportunity of holding budgets in order to achieve a greater integration between themselves and the hospitals and, in doing so, leveraged their power position within the NHS (*Llewellyn, 1997*).

Within the hospitals, doctors have been more cautious about an engagement with a managerialist agenda (Pollitt et. al., 1988; Preston et.al., 1992; Harrison and Pollitt, 1994). However the institution of clinical directorates resulted in some doctors assuming a “two-way” orientation between medicine and management through budget- holding (*Llewellyn, 2001a*). In this case their motivation was driven, first, by the realisation that if clinicians did not assume the responsibility to manage medicine, managers would, and, second, by a prescience of positioning clinical directors advantageously in the strategic decision-making of the hospital (*Llewellyn, 2001a*).

In terms of an engagement with managerialism, the expertise of surgeons is closer to that of managers than is the expertise of physicians (*Llewellyn, 1999*). The action orientation of surgical work is reliant on the cultural values of strength, heroism and boldness to legitimate its interventionism (Abbott, 1988, p.188). These attributes mirror the characteristics of strength, boldness and aggression implied by management and leadership (Mills, 1993). The bias-for-action mentality of surgeons is reflected in the “super-hero” management literature (c.f. the work of Drucker, 1968 and Peters and Waterman, 1982). In addition, the nature of surgical work indicates that it will be more easily penetrated by a managerialist agenda. Surgery involves an action-sequence, is of an interventionist nature and takes place within a limited time frame; it has clearer outcomes (than medicine) and is, therefore, more amenable to counting and measurement (*Llewellyn, 1999*). The practice of management, in terms of techniques to promote organizational efficiency, value for money and accountable performances, is more aligned with the practice of surgery than that of medicine.

Inputs and outputs are not transparent in medicine. Hence technical efficiency (in the sense of an optimal relationship between inputs and outputs) is not easy either to establish or to achieve in medicine. Physicians are not as able as their surgeon colleagues to argue for

resources in the managerial categories of productivity and efficiency. These differences between surgeons and physicians resulted in a differential take-up of clinical budget-holding, with many more surgeons than physicians assuming the management role of medical director (*Llewellyn, 1999*).

The differentiated nature of the health services results in multiple points of both receptivity and resistance to managerialism. This heterogeneity within health can be understood as equating to its many and different intersections of power/knowledge (Foucault, 1972; 1979; 1980; 1986). The relative powerlessness of GPs vis-à-vis the hospital consultants and the differential nature of the knowledge base in surgery vis-à-vis medicine offer examples of why managerialism has met with an uneven response in the NHS. GPs saw an opportunity to increase their power in relation to the consultants (*Llewellyn, 1997*). Surgeons tend to feel a greater affinity with managers (than do physicians) as the practices of surgery and management have some commonalities (*Llewellyn, 1999*). Scarbrough (1995) identifies expertise as "...the medium through which knowledge grasps power...(p.28). The field of health care offers differential opportunities for clinicians to grasp power through the assumption of budget-holding; hence the uneven response to management across the NHS.

In contrast, managerialism has advanced across more homogeneous terrain in the social services. As an organization firmly located towards the bureaucracy end of the bureau-professional spectrum, the social services have been more bound by prescriptive rules that ensured more uniform responses to events (*Llewellyn, 1998b*). Moreover, a strong organizational culture, embodying shared moral values, enables a collective response to problem-solving. The social services are not characterised by differential sites of power/knowledge in the way that the NHS is; therefore, the impact of budget-holding has been less variable – as less opportunities have been around for power re-negotiations. However, there has been a range of different individual responses to managerialism in social work. As in health, individuals with a more entrepreneurial mind-set have embraced management ideologies, resulting in a "patchy" reaction across individuals (*Llewellyn, 1998b*; *Llewellyn, 2001a*). The clearest differentiation in response to managerialism in the social services is between front-line workers and more senior management. Practising social workers (now care managers), as front-line workers, have to justify decisions in face-to face situations with clients (*Llewellyn, 1998a*). If tight budgets do not stretch to meet clients' needs, the "emotional labour" (Langan and Clarke, 1994) involved with clients may be considerable. In contrast, senior management is positioned away from the front line of service delivery and has the responsibility for ensuring overall financial control. Hence the

differential enthusiasm between the inner core (of senior management) and the outer periphery (of front-line workers) in social services for managerialism is not surprising.

There is some comparability in terms of their alignment with a managerialist agenda between physicians and social workers. The higher uncertainty in diagnosis and treatment in medicine (than surgery) gives rise to a greater use of, "...experience, trial and error, intuition and muddling through." (Schön, 1991, p.43). Moreover, physicians (as social workers) tend to deal with patients/clients with multiple problems with unclear prognoses. Hence, the trajectory of care in medicine is more complex and open-ended (than in surgery). These issues make the work of physicians and social workers less easily standardised (than that of surgeons). Moreover, an "optimal" relationship between inputs and outputs is more difficult to assert in medicine and social work, than it is in surgery. In these ways, the boundary between management and surgery is less secure; this can be seen in the greater use of protocols and guidelines in surgery, in the establishment of twenty-four hour routine surgery centres and the easier production of surgical costs for benchmarking purposes (Northcott and Llewellyn, 2001; Northcott and Llewellyn, forthcoming). These circumstances indicate that the impact of managerialism has had a differential balance of advantage and disadvantage between medicine (and social work) and surgery. Surgeons are more able to argue for resources in management terms but their practice is more subject to processes of rationalization than their medical colleagues. In the social services, work practices are not transparent in managerial terms but the greater level of bureaucratization in social work (see above) has, nevertheless, enabled high degree of penetration for management agendas.

CONCLUDING DISCUSSION

The above sections have delineated some of the key differences between the NHS and social services in terms of the impact of boundary work at the interface between professionalism and managerialism; this concluding discussion focuses more on some of the similarities.

The logic behind the devolution of budgets throughout the public sector is to ensure that "...resources flow to the point in the organization where user needs are assessed." (Langan and Clarke, 1994, p.81). The idea being to couple "caring" and "costing" in a unitary set of tasks undertaken by an individual. Previously "caring" and "costing" operated as "internally circular structures" (Luhmann, 1989, p.15) driven by professional and managerial groups who had little contact with one another. In order to integrate the tasks of costing and caring boundary work has been carried out. The empirical papers illustrate some commonalities in the ways in which the boundaries between professionalism and managerialism have been

dissolved as professionals decide that some aspects of management can have beneficial consequences for their practice.

First, professionals occupying boundary roles (care managers, fundholding GPs or clinical directors) embody, through their work, sets of ideas belonging to professionalism (“caring”) and sets of ideas associated with management (“costing”). This “two-way” orientation leads to some integration between professionalism and managerialism (Llewellyn, 2001a). Boundary workers come to perceive that costing may, in some circumstances, enhance caring (Llewellyn, 1997; 1998a). Some care managers and GP fundholders judged that a greater degree of cost consciousness could, conceivably, result in savings and, therefore, more money to spend on caring (Llewellyn, 1997; 1998a). Another way in which professionals think that budgeting may enable “caring” is when a budget is allocated to what was, previously, a “Cinderella” area. Care managers commented on how the budget for community care had resulted in a shift in focus away from child welfare- previously the highest priority client category (Llewellyn, 1998a). GP fundholders remarked on how they were able to use allocated resources to introduce community psychiatric services and complementary medicine (medical hypnosis, aromatherapy and reflexology) (Llewellyn, 1997).

Second, certain professionals perceived that some of their colleagues were exploiting or even abusing their professional autonomy and, that, more active management would “bring them into line”. Some of the surgeons were aggrieved that a sub-set of their medical colleagues persistently overspent their budgets (Llewellyn 1999; Llewellyn, 2001a). A few of the care managers commented that budgeting went some way to preventing individual social workers overspending to the detriment of other colleagues and other clients (Llewellyn, 1998a). Clinical directors were keen to curtail colleagues who continued with idiosyncratic practices (for example, by maintaining longer than average length of stay with no appropriate clinical indications) (Llewellyn, 2001a).

Third, professionals perceived that there were areas where the greater degree of formalization associated with management was beneficial to “caring”. For example, social workers judged that contracting with care home owners could sometimes prevent abuses of client rights (Llewellyn, 1998a). GP fundholders related instances where consultants were now more careful about care management issues (e.g. patient discharge letters and communication of information relating to changes in clinical practices in the hospitals). Clinicians in the hospitals perceived that more management expertise was required on the risk management aspects of clinical practice in the more litigious contemporary environment (Llewellyn, 2001a).

Fourth, in all areas of the public sector there have always been professionals who have some sympathy with management agendas and ideologies. The preceding section has analysed in some detail the more managerialist mind-set of surgeons (than physicians) and the greater compatibility of surgical work (than medical) to the management categories of efficiency and productivity. But, aside from these group alignments, there are also individuals who are more management oriented. There are clinicians who enjoy the tasks of organizing, budgeting and ensuring organizational accountability (*Llewellyn, 1999*). Some GP fundholders relished negotiation and bargaining with the hospital consultants (*Llewellyn, 1997*). A few social workers got “a gleam on their eye” at the opportunity to act in an entrepreneurial, even combative, way (*Llewellyn, 1998a*). Some professionals were liberated by the more managerial climate in public services!

Managing expert labour

Expertise and money are the fundamental resources in public sector organizations. Practising professionals can use their exclusive claims to the control of expertise in the public sector to circumvent change. They have also, traditionally, mobilised their knowledge-power-expertise to make the individual decisions that have driven the allocation of money in the public sector. Increasingly, however, rather than money being held centrally (with global budgets as the norm) managerial professionals are using their power to devolve budgets to enhance their control of public sector activities. Money is being utilised both as a means of achieving some integration between managerial and professional work and as a way of controlling the professionals. Hence, the allocation of money is a potentially powerful way of managing expert labour. The empirical papers in this thesis illustrate some of the various consequences of using money as a mode of control in public services.

When money conveyed purchasing power on GPs, the channels of communication between primary and secondary care were re-opened¹⁶ (*Llewellyn, 1997*). Previously the separately secured funding of the hospitals and the higher status of clinicians in secondary care combined to isolate GPs from the medical schools and to silence their voices in negotiating clinical developments. The power of budgets to dictate “what’s do-able” in professional practice was clearly evident in both health and social care (*Llewellyn, 1998a and Llewellyn, 1999*). Albeit that, in the social services, tight financial constraints dictated that collective responses were made to management’s attempts to devolve financial responsibilities to

¹⁶ This “re-opening” may have taken the form of an additional renewal of communications if there had been significant private referrals between the GPs and the local consultants.

particular individuals (*Llewellyn, 1998b*). There were also indications of a more managerial work orientation (consequent on delegated budgeting) in both health and social care, albeit that some areas (for example, surgery) had a greater initial receptivity to key management categories. Moreover, there were differential possibilities for professionals to enhance their power-base through assumption of management responsibilities. In health care there were examples of professional advance through budget-holding (e.g. GPs (*Llewellyn, 1997*) and clinical directors (*Llewellyn, 2001a*) whereas in social services the result of delegated budgets was solely to increase the control of senior management (*Llewellyn, 1998b*). In the hospitals there was evidence of a new area of expertise emerging- that of “medical management”. This emergent domain looks to be professionally dominated (*Llewellyn, 2001a*). The implications of using money as a control tool in the public sector are, on the evidence of the work in this thesis, highly domain specific.

Several pressing issues indicate a requirement for greater integration between managerial and professional knowledges in the public sector. Determining the strategic direction of public services, instituting an aggregate approach to service delivery, dealing with technological advance (in the context of resource constraints), implementing risk management, negotiating rising consumer expectations and utilising public-private partnerships all require a “knowledge in the world” approach. Creating expertise that overlaps professional and managerial work, through integrating “caring” and “costing”, is a key challenge for public sector management. This thesis has sought to make a contribution in this area.

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APPENDIX 1

Illustrations of the hermeneutic methodology in the empirical papers

Proposition One that the sense content of action must be drawn out is evident in the narrative accounts of all four papers. For example, the proposal in *Llewellyn 1999* that the orientation of surgeons is closer to a management perspective than that of physicians was deduced from comparing the actions and attitudes of surgeons against the actions and attitudes of managers (first order constructs). Not all surgeons were consciously aware of a closer alignment with a management agenda, but an analysis of their actions indicated that this was the case. This closer alignment fosters different terms of engagement with managerialism for surgery than medicine. Thus the penetration of the clinical realm by managerialism (a second order construct (or social product)) differed between surgery and medicine.

Proposition Two on the possibility of institutionalization was demonstrated, for example, in *Llewellyn, 1998b*. Social workers were diffusing budget responsibilities in order to avoid painful “emotional labour” with clients when budgets did not stretch to meet needs (a first order construct). However, these individual responses were rapidly becoming institutionalized as social products as the “normal” reaction to budget pressures.

Proposition Three on actions developing meanings in other social contexts is seen, for example, in *Llewellyn, 1997* where the latent conflict between the GPs and hospital consultants (first order constructs) took on a new dimension under fundholding. GPs were able to launch a professional challenge (a social product) against the consultants under the auspices of fundholding as a political initiative.

Proposition Four on the “open” nature of interpretation is again evident in all the papers. One example is the understanding of the doctor-manager role (*Llewellyn, 1997, 1999, 2001a*). The example of GPs who were “early-takers” in fundholding indicated an enhanced power position for them in the NHS (first order constructs). But the evidence on clinical directors has been more ambiguous. There are indications that some of these doctor-managers are becoming new “clinical bosses”, on the other hand it could be argued that they are acting as subordinates to NHS general managers. The story of the power-positioning of doctor-managers (a social product) is an on-going one.

Implication One is again demonstrated in the narratives of all four papers in the sense that these narrative accounts are “metastories”. Metastories interweave quotes from the interviewees with theoretical understandings that will not usually be available to them. One

example is the analogy in *Llewellyn, 1999* of surgeons as counters and physicians as philosophers. This builds on but also extends the self-understandings of the clinicians involved in the study.

Implication Two -that processes of projection and modification generate the research insights- was shown, for example, in *Llewellyn 1998a* where the “boundary work” thesis was taken back at the second stage of this research for comment and amendment from the interviewees.

Implication Three is also seen in all the papers. For example, the narrative in *Llewellyn 1997* begins at the inception of the fundholding scheme and is focussed on key players. These boundary definitions produce a very different account of the impact of fundholding than would be obtained from the later “takers” or, indeed, from non-fundholding GPs.

Implication four on the intrinsically critical nature of hermeneutic research is again apparent in all the papers. One example is that the strategies identified in *Llewellyn 1998b* to diffuse budget responsibilities (first order constructs) may be appropriated and extended by other care managers. Such an approach would be a part of the change trajectory (or social product) in the social services.

THE PUBLISHED PAPERS

Working in hermeneutic circles in management accounting research: some implications and applications

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Ways of thinking about accounting have changed. Management accounting, in particular, has escaped from being encompassed by a set of calculative procedures. It is now accepted that accounting has organizational and social significance simultaneously reflecting and shaping both structures and ideas. Consequently there has been increasing research interest into the meaning and roles attributed to accounting, processual change in accounting, and accounting histories. Such extensive definitional and boundary changes inevitably brought into focus an issue which was previously unproblematically peripheral to the concerns of accounting researchers—that of methodology. There has been some realization that what is researched and how it is researched are interlinked—that new research methodologies will reveal new research agenda. However, this heightened awareness of the importance of methodology has not been matched by a consideration of its implications for empirical accounting research. This paper seeks to redress this imbalance by, first, identifying a nexus of ideas from hermeneutics—ideas which understand action as a text analogue—and, second, drawing out some substantive conclusions on what the adoption of such a methodology would mean for empirical, interpretative accounting research.

Key words: hermeneutics; methodology; interpretive; empirical; case study methods.

1. Introduction

For a time in management accounting research two prescriptive arguments existed side by side; then they began to converge. First there were calls for the correction of a perceived imbalance between normative theorizing (when abstracted from any real-life context) and empirical research; less of the former and more of the latter was prescribed (Tomkins and Groves, 1983; Kaplan, 1986; Scapens, 1990). The usefulness of normative theory, when founded on the assumption that introspection and deduction could improve accounting without reference to its practical functioning within organizations, was challenged by researchers such as Kaplan who cited the need for a science of management accounting to be built upon empirical research using the tools of observation, classification and measurement. However, this advocacy of empirical work remained implicitly positivist. Its aim was the faithful representation of practice

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in order that systems could be designed to enhance the 'relevance' of accounting to modern organizations (Johnson and Kaplan, 1987, Johnson, 1992). Meanwhile, a parallel development was occurring—the theoretical claims of traditional mainstream positivist research to portray 'mirror-like' representations of an objective reality were increasingly being questioned by an emerging interpretive research agenda. Hines (1989) has termed this agenda 'the sociopolitical paradigm'.¹ From such a perspective '...researchers aim to understand the meanings which are given to accounting in particular settings,' and researchers are aware that '... order is as much constructed as it is revealed by accounting means.' (Hopwood, 1983, p. 288, p. 294). As the interrelationship of these prescriptive arguments became more apparent a new area of inquiry opened up for accounting researchers and this new research agenda suggested a fruitful convergence between the interpretive and the empirical traditions.

The developments outlined above allowed the crystallization of certain key clusters of new interpretive research questions. These were, first, an understanding of the meanings and roles attributed to accounting (Burchell *et al.*, 1980; Hopwood, 1983; Meyer, 1986; Lavoie, 1987; Richardson, 1987; Miller and O'Leary, 1990), second, a critical assessment of the accounting endeavour and the potential for radical accounting change (Cooper, 1983; Laughlin, 1987), and third, inquiry into the situated nature of accounting tracing its spacial and temporal trajectories (Hopwood, 1987; Loft, 1986; Miller *et al.* 1991). That the boundaries of management accounting research have shifted in this way is of interest in itself. Edwards and Emmanuel (1990) conclude that, '...management accounting is a discipline in transition.' (p. 61). But despite the widening domain of interpretive accounting research and within this extended domain the identification of specific research themes, there has not been a proliferation of qualitative empirical studies. That this has not happened may be due, in part, to the exigencies and imperatives of academic life which inveigh against time-consuming qualitative work (Willmott, 1983) but there are other underlying issues.

Before exploring these issues, the structure of the paper is explained. Following this introduction the paper falls into two parts: first, there is a discussion of hermeneutics as a methodology, identifying some basic propositions and implications for empirical research and, second, there is an analysis of the potential impact of hermeneutics by reference to two completed case studies from the management accounting literature. These studies are Dent's (1991) analysis of change at the railways, 'Accounting and organizational cultures: a field study of the emergence of a new organizational reality,' and Innes and Mitchell's (1990) paper on the electronics industry, 'The process of change in management accounting: some field study evidence.'

Some issues in the development of interpretive work

This paper introduces hermeneutics as an interpretive methodology, in doing so it argues, first, that the methodology adopted will shape the research process and the research findings to a far greater extent than will the research methods. The following distinction between *methodology* and *methods* is proposed—that methodology reflects the ontological and epistemological assumptions of the researcher (particularly those concerning the relationship between subject and object) whereas methods are secondary concerns around the techniques used for data collection. There is still a lack

¹Hines used this phrase to describe theoretical developments which encompassed financial accounting. This paper concentrates on management accounting, however, the phrase is still descriptive of the shift away from positivist research whether applied to management accounting or financial accounting.

of clarity on this distinction (see, for example, Spicer, 1992). One of the central themes of this paper is that interpretive empirical work should be explicitly grounded in a methodology rather than a method (Llewellyn, 1992).

Where subject and object are thought to be independent, as in positivist research, the subject conceptualizes the research as the observation and recording of information about the object. However, in social science the object of the research will be a social one. 'Social' objects, as compared with natural objects, have features which complicate the research process. Social objects will be 'intrinsically meaningful' (Sayer, 1992) or 'concept-dependent' (Bhasker, 1979). Thus in, for example, the Dent study on the process of change at the railways, rail travel with its associated cultural and material practices was already constituted as meaningful both for railway employees and for the researcher. Thus when an interpretive researcher seeks to understand what the railways mean to those who work there, this understanding will, in part, be informed by the researcher's own pre-understanding. In addition, in any social setting, systems of meaning will be 'reciprocally confirming' (Williams, quoted in Sayer, 1992) with work practices. Changes in work practices will, therefore, be accompanied by changes in their meaning. Thus the meanings attributed to work practices are not just in the minds of those engaged in them, what social phenomena '*...are depends on what they mean in society to its members.*' (Sayer, 1992, p. 30, emphasis in the original).

The major difference between interpretive and positivist research is that interpretive research will attempt, in some way, to address these connections between subject and object and between meanings and practices. The proposition that methodology, not methods, has primacy in the research process is explored further in the third section of the paper where it is shown that the knowledge generated in the Dent and the Innes and Mitchell studies was quite different (although both projects were case study based and used semi-structured interview techniques) thus demonstrating the crucial role of methodology in the production of knowledge. Therefore, although interpretive accounting researchers frequently employ case study methods (along with other tools such as archival research, verbal analysis or participant observation) such procedures remain data collection techniques as they cannot and will not be sufficient to provide a methodological framework for interpretive management accounting research.

Second, although there has been an increasing interest in methodology stemming from a recognition that the research methodology and the object of the investigation are linked (as was outlined above, new research questions around accounting change, roles and histories cannot be disentangled from empirical and interpretive means of enquiry) there has been a lack of clarity and precision to the term 'interpretive' as a methodology.² That interpretive methodologies have been rather nebulous in content is, in part, a consequence of the confusion between methods and methodologies (as discussed above). Sometimes the terms 'method' and 'methodology' have been taken to be interchangeable. On other occasions methodology has been equated with the way that interpretive accounting researchers deal with the criticisms (around validity, reliability and generalization) of case study methods put forward by the positivists (Spicer, 1992). Where an interpretive methodology has been explicitly adopted it has

²The (1990) Covalleski and Dirsmith paper is an exception to this in its explication of double reflexivity and dialectic tension in interpretive work. However, the earlier 'methodology' papers (Tomkins and Groves, 1983; Hopper and Powell, 1985; Morgan, 1988; Chua, 1988) concentrated on the classification of a range of ontological and/or epistemological assumptions to the neglect of a consideration of how such assumptions would shape the research act.

tended to limit the research findings to an explication of the subjective realms of agents' experiences (this propensity is examined more closely later in this paper with reference to the Dent study).

Third, scant attention has been paid to tracing the implications of an interpretive methodology for empirical research. Where a prior theoretical framework has been adopted by interpretive management accounting researchers, such a framework, rather than constituting a methodological stance, has tended to form the explanatory medium through which the research findings are interpreted.³ The work of Habermas, Giddens and Foucault has been used in this way (see Laughlin, 1987; Macintosh and Scapens, 1990; Stewart, 1992). The purpose of this paper is not to deny the potential of such approaches but to argue that research can proceed from a less encompassing initial position and still be methodologically informed. Such an approach should more readily generate new theoretical insights [cf. the classic grounded theory tradition of Glaser and Strauss (1967)] than will the use of extant social theories. The adoption of a hermeneutic approach to interpretive research will, first, show how assumptions on subject-object relations shape the research process and, second, reveal some specific implications for empirics.

2. Hermeneutics: what it is

Before turning to the detail of an hermeneutic approach, this section starts by relating 'hermeneutics' to interpretive, qualitative and naturalistic—terms which are already familiar from the accounting research literature. 'Qualitative' and 'naturalistic' have both been used as descriptive of both methods and methodology. When used to indicate method 'qualitative' has been '... an umbrella term applied to a number of interpretive techniques directed at ... inferring the meanings of events or phenomena occurring in the social world' (Covaleski and Dirsmith, 1990). As a methodology 'qualitative' has referred to processes of understanding, rather than explanation, particularly contextual understanding. Tomkins and Groves (1983) consider that the essence of 'naturalistic' methods lies in their study of human behaviour 'in its natural setting' (p. 364). As a methodology they link 'naturalistic' with idealist ontological assumptions. In order to locate hermeneutics within the 'interpretive' school in accounting research the following comments are made: hermeneutics denies the objective-subjective dualism which is set up in some interpretive approaches (for example, Burrell and Morgan, 1979). Therefore hermeneutics is not solely concerned with the explication of subjective meanings. Indeed, in the Ricoeurian version which is used here, hermeneutics focuses on social action (or practice) as an active relation between the realm of ideas and the realm of real, material objects (Sayer, 1992, p. 205). A Ricoeurian version of hermeneutics would also reject the notion that explanations are inappropriate in the social sciences. The presence of unarticulated structural conditions (or stable relations) invoke the need for explanation as well as subjective understanding. This is expressed by Thompson (1981),

'For example, there are relations of production and distribution, hierarchies of power and processes of legitimation, all of which may remain wholly or partly opaque to the actors which they enmesh' (p. 157).

³It is recognised that there can be no clear-cut distinction between a 'methodological stance' and the adoption of a fully-developed social theory as a theoretical framework (both involve the articulation of values), nevertheless it is argued that the latter position will be more directive and tend to substantiate the initial theory rather than producing new knowledge.

Hermeneutics can be described as the *theory* of interpretation. As a theory it draws parallels first, ontologically, between certain aspects of social action and certain features of a text and, second, methodologically between the understanding of social action and the interpretation of a text (Ricoeur, 1981, p. 197).

The origin of the word 'hermeneutics' lies in its use as a means of describing the process of recovery of meaning. Hermeneutic was the word applied to a quest which was concerned to recover the authenticity of certain ancient, usually biblical, texts, where original meaning had been lost through successive translations (Ricoeur, 1974, p. 64). Hence, historically, the meaning of hermeneutics encompassed the notion of a search: the search for authentic knowledge. Gradually, however, the sense of the word began to change—usage as 'recovery of meaning' giving way to the more modern use as 'interpretation of meaning' (Bauman, 1978, p. 10). This shifting emphasis enabled a parallel development: the application of the ideas which are encapsulated in the word to some of the methodological problems in the social sciences as research seeks to interpret the '... situated practices of individual social actors.' (Scapens, 1992).

What follows is selective in its sources for a hermeneutic way of thinking⁴ in interpretive research. Ideas are drawn predominately from Ricoeur. The main aim being to identify themes which can ground interpretive empirical work in management accounting, clarifying and sharpening claims to 'interpretive methodologies'.⁵ A first step is to take a theme from the (1981) work of Ricoeur: that the understanding of social action can be considered analogous to the reading of a text. Unless this connection is established the links between hermeneutics and interpretive methodologies remain tenuous. Ricoeur's argument is that, in so far as the analogy holds, the problems of understanding human actions will mirror the difficulties of textual interpretations (p. 197). To elucidate this problematic and develop the analogy between the interpretation of texts and that of human action Ricoeur points to four ways in which the meaning of an action becomes detached from the event of the action, thereby becoming objectified and thus an appropriate focus for the act of interpretation.

First, human action and written text can be analysed for their sense-content (p. 205). This 'sense-content' is not fully encompassed by the intentions and motivations of the actor or writer, although grasping the inner deliberations of the actor/writer will usually be a first step. The purpose of analysing the sense-content of action is not to restrict analysis to only those actions which are rational or which avoid contradiction

⁴The work of Heidegger, Dilthey, Gadamar and Ricoeur and, subsequently, Giddens and Taylor progressed and advanced the concept of hermeneutics. Dilthey established a dichotomy between understanding in the social sciences and explanation in the natural sciences by positing that human action must be understood by grasping the subjective consciousness of the agent whereas the natural world must be causally explained from the outside. Gadamar, however, held a version of *verstehen* which emphasized not the inner experience of agents but the authority of history as underlining meaning. This paper in no way attempts to portray the subtle distinctions which lead these thinkers to occupy various positions within the hermeneutic tradition nor does it address the various critiques of hermeneutics. For a recent discussion of the idea of action as a text see Thompson (1993).

⁵There have been previous papers in the accounting literature which explored aspects of the hermeneutic tradition. These include Willmott's (1983) discussion of what he terms the 'historical-hermeneutic sciences' and their contribution towards a paradigm for accounting research, Lavoie's (1987) advocacy of hermeneutics as underpinning an understanding of accounting as the language of business, and Boland's (1989) paper which attempts to synthesize the 'objective' and 'subjective' traditions in accounting research through a hermeneutic turn of thought which rejects the objective-subjective dichotomy.

but to find,

'... a coherence between the actions of the agent and the meaning of the situation for him... the meaning of the situation may be full of confusion and contradiction; but the adequate depiction of this contradiction makes sense of it' (Taylor, 1979, p. 35).

These ideas can be summarized as:

Proposition One: The 'sense-content' of action and text must be drawn out; comprehension cannot be immediate or unmediated.

The way in which this is accomplished (through projection and modification) is discussed in the section which sets out the implications of these propositions for empirical research.

Second, action and text are capable of becoming detached from the person who performed or wrote them and can acquire a social dimension (p. 206). This implies that an action can be understood not only as a personal endeavour but also as a social product. The social nature of individual action has two facets: its antecedents and its consequences. Any action has antecedents which are not fully encompassed by the personal motives of the agent. 'Behaviour' cannot be understood in isolation from that set of social 'rules' by which it is regulated and from which it derives its meaning. Such 'rules' are known to the agent but some of the conditions for social action are unknown. Hierarchies of power, processes of legitimation, and relations of production (Thompson, 1981) are all social structures which may be opaque to the agents concerned. Thus both the 'rules' which define the socially-given content of individual action and the social structures which constrain the scope and power of individual endeavour present as objectifications which negate the equating of the antecedents of action with the personal motives, reasons and intentions of the agent. Once done, as Ricoeur remarks, '... our deeds escape us and have effects we did not intend'. (p. 206). It is through this 'sedimentation in social time' (p. 207) that institutions, such as accounting, become objectified and present as a social reality which simultaneously enables and constrains individual action. It is this process which generates the links between systems of meaning and material practices so that what practices are is, in part, dependent on what they mean in society. Thus,

Proposition Two: The text or the action has both personal and social significance—its social dimension implying the possibility of institutionalization.

Third, the relevance and importance of an action can transcend its circumvention within any initial situation. Ricoeur refers to this property of action as the opening up of 'non-ostensive references',

'An important action... develops meanings which can be actualized or fulfilled in situations other than the one in which this action occurred... the meaning of an important event exceeds, overcomes, transcends, the social conditions of its production and may be re-enacted in new social contexts. Its importance is its durable relevance and, in some cases, its omni-temporal relevance.' (p 208).

In other words action, as a text, can become a 'referent'. By 'leaving a mark' (p. 206) an event can contribute to the emergence of patterned action or institutionalization. Actions or events may thus escape their initial definitions and circumstances and become focal points for individuals or for whole communities. The symbolic meaning of such events will be pervasive and enduring. Hence,

Proposition Three: The text or the action may transcend its encompassment within its initial circumstances and develop meanings in other social contexts.

Finally, human action, as is a text, is an 'open work'. It is 'open' in two senses. First, it is 'open' to anyone who can read (p. 208). Thus the 'interpretation' of action is not the specialized province of the researcher but is a universal, integral and necessary condition for the continuity of social life. As action may be interpreted by an infinite number of readers its meaning is essentially 'in suspense' (p. 208) and fresh significance can always be placed on an event by invoking a new and different frame of reference. Thus human action is 'open' in a second sense—there are no compelling certainties attached to any particular interpretation. This insight is reflected in Willmott's (1983, p. 399) view of hermeneutics as acknowledging the historically bounded nature of understanding. The transient nature of any interpretation has dual consequences. No interpretation can claim to be definitive but any action can receive fresh relevance and interest by being viewed from a new perspective. If the essentially transient nature of interpretation is accepted then it can be seen that the conceptual innovation that this implies in turn alters human perceptions of reality. This casts the possibility of prediction in the human sciences in a new light. For if, 'the very terms in which the future will have to be characterized . . . are not available to us at present' (Taylor, 1979, p. 69), then prediction is, at least imperilled, or, at most negated, as the linguistic categories of the future are not yet available. The past may be re-conceptualized with the ideas of the present but the future cannot be captured if its terms of reference are not yet available. Introspection reveals that such a dilemma is often reflected in our experience of change.

'Often one has the sense of impending change . . . but is powerless to make clear what it will consist in: one lacks the vocabulary' (Taylor, 1979, p. 70).

This interdependence between our grasp on social reality and the language available to conceptualize it has been described by Bhasker (1979, p. 28) as the concept-dependence of social reality.⁶ It is the concept-dependence of social reality along with the potential for conceptual innovation which renders our understanding of social action inescapably contestable and transient. Hence,

Proposition Four: Textual interpretation and social understanding are both essentially 'open' in nature.

To re-cap, four reasons can be offered for the understanding of social action as a text-analogue. These reasons refer to the four areas of congruence between *verstehen* in the social sciences and textual interpretation and are shown in Table 1. That these propositions are basic to the hermeneutic endeavour can be seen by locating them within Giddens' notion of the 'double hermeneutic' (1976, p. 162; 1982, p. 11; 1984, p. 284). The researcher encounters a realm in the social world which is already meaningful to the agents involved. Agents' interpretations have been accomplished by reference to their own values and beliefs and by what they perceive as the 'contextuality' of their action. 'Contextuality' is here equated with the 'setting' of the action and defines the agents' awareness of the processes and structures which they use to orient and make sense of their action (Giddens, 1987, p. 215). Thus Proposition One

⁶Bhasker does not, however, accept that the nature of social reality is exhausted by its intrinsic 'concept-dependence'. His view is that social reality has a material aspect and cannot, therefore, be reduced to agents' conceptualizations of it.

Table 1
Hermeneutic propositions

Proposition One:	The 'sense-content' of action and text must be drawn out; comprehension cannot be immediate or unmediated.
Proposition Two:	The text or the action has both personal and social significance, its social dimension implying the possibility of institutionalization.
Proposition Three:	The text or the action may transcend its encompassment within its initial circumstances and develop meanings in other social contexts.
Proposition Four:	Textual interpretation and social understanding are both essentially 'open' in nature.

implies that the 'sense-content' of social action must be explicated through these first-order constructs (Giddens, 1984, p. 284) but is not restricted to such constructs. That the 'sense-content' of action is not confined to agents' own reasons, motives and values lies in its nature as a social product. Consequently researchers can construct 'second-order constructs' using their own 'technical' language which re-interpret the action, events and experience of the researched (Proposition Two). However, as human action is essentially an 'open work' (Proposition Four) the researched may choose to appropriate the 'second order constructs' of the researchers. Hence these 'second-order constructs' may re-emerge as 'first-order constructs' presenting as fresh research material and so on. Therefore,

'The concepts, theories and findings generated by sociology 'spiral in and out' of social life, they do not form an ever-growing corpus of knowledge' (Giddens, 1987, p. 32).

The implications of hermeneutics for empirics

Thus it is argued that hermeneutics can offer a methodology which transcends those interpretive perspectives which limit research to the understanding of the subjective realm of experience. The subjective-objective duality⁷ posed, in part, to emphasize the inadequacies of positivism as a methodology restricts the development of interpretivism if such research cannot go beyond grasping the significance of action from the actors' point of view. However, the adoption of Proposition Two leads to a rejection of this boundary.⁸ Proposition One finds the 'sense-content' of action in its coherence with the meaning of the situation for the agent but Proposition Two contends that interpretive work can go beyond this. That the antecedents and consequences of action are often opaque to the agent implies that the interpretation of action can have a power of disclosure which transcends the limited horizons of the existential situation of the agent (Rabinow and Sullivan, 1979, p. 12) Thus the notion of human action as a social product is closely associated with the post-structuralist notion of the 'decentring of the subject' (Giddens, 1987, p. 86) and argues that research can transcend agents'

⁷Dow's (1990) paper 'Beyond Dualism' provides a useful analysis of the conflicts which have arisen in economics through the inherently uncertain nature of economic 'realities' being portrayed through predominately dualistic methodologies and theories. Much of her argument could be applied to accounting research when attempts are made to capture the 'endemically uncertain' (p. 146) in the form of duals instead of recognising that opposing categories (e.g., the subjective-objective) obtain their meaning partly from each other (p. 144). Such categories are better regarded as mutually informing rather than mutually exclusive.

⁸Boland's (1989) paper takes Morgan's Images of Organization as an exemplar of a hermeneutic work in its rejection of the subjectivist-objectivist dual for the presentation of eight different metaphors which construct our understanding of the nature of organizations.

interpretations; it can go beyond what Thompson (1981, p. 38) has termed 'experiential empathy'. This can be summarized as,

Implication One: Researchers can legitimately offer accounts of events which either differ from or transcend the understandings of agents themselves.

Proposition Four outlines the nature of human action as an 'open work' and points to the second implication of hermeneutics for empirical research: the inevitability of the 'hermeneutic circle' of understanding and explanation. The concept of the hermeneutic circle is the most widely recognized defining idea in the hermeneutic tradition but it has two rather different sets of associations. First, the hermeneutic circle describes the processes through which the subject and the object of the research become more aware of the concepts and ideas which guide their thinking and of their inherent emancipatory and/or constraining qualities. To any 'reading' of an event in the social world the researcher always brings interpretive skills and some kind of pre-understanding of what the event is about. The pre-understanding of both researcher and researched is constituted by their belonging '... to a history, to a class, to a nation, to a culture, to one or several traditions.' (Ricoeur, 1981, p. 243). A heightened awareness of such pre-understandings can lead both researchers and researched to strive to attain more adequate conceptualizations through, first, critical reflection and, second, an engagement of their disparate frames of reference. Subject and object are thus 'mutually implicated' (Ricoeur, 1981, p. 57) in a commitment which, for Ricoeur, embodied an ethic. From this comes the first meaning of the hermeneutic circle—the research findings will reflect a tacking backwards and forwards between the pre-understandings of the researcher and the 'first-order constructs' of the researched. That these have commonalities makes the research possible; that they have divergencies should make the research fruitful. The commitment of the researchers and the researched 'energizes' the hermeneutic circle and ensures that the 'circle' does not become a 'vicious circle'. (Ricoeur, 1981, p. 221). Rickman (1976) describes the process and its influence:

'This circularity—or perhaps one might call it a spiral approximation towards greater accuracy and knowledge—pervades our whole intellectual life.'

From this first notion of the hermeneutic circle (or spiral) comes the second implication for empirics:

Implication Two: The research insights will be generated by the processes of projection and modification. They will reflect a synthesis of the frames of reference of the researcher and the researched.

Projection and modification supplants Popper's (1959) model of conjecture and falsification (through testing) because hermeneutics is concerned to produce knowledge of relationships in open systems. The possibility of 'emergent powers' (Sayer, 1992, p. 122) in open systems means that regularities cannot be assumed to continue indefinitely (cf. Propositions Two and Three). Hence falsified prediction does not necessarily imply that the theory being 'tested' is defective. Hermeneutics is, therefore, particularly appropriate in conditions of processual change where emergent powers are transforming social relationships and thus negating the possibility of prediction.

The second set of ideas implicit in the hermeneutic circle encompasses the inevitably holistic nature of interpretive research. For interpretive empirical work there is no

obvious starting point (Rickman, 1976) nor are there obvious boundaries to the research problem, field or agenda. What this means is that the research 'whole' is constituted by the fixing of its parts and, in turn, how the research 'whole' is defined will constrain what its parts can consist of. Once these boundaries are set the research 'whole', as problem, field or agenda, is understood by reference to its 'parts' and the parts only make sense through their contribution to the 'whole'. Consequently the research findings will take the form of a narrative but this narrative is not constituted by a succession of episodes but constructs 'a meaningful totality from scattered events' (Ricoeur, 1981, p. 278). The holistic associations of the hermeneutic circle coalesce to the third implication of empirical work,

Implication Three: The interpretive research act is a creative endeavour whose inner coherence rests upon the starting point and boundaries which are imposed in the course of the research.

Proposition Two posits human action as concept-dependent and Proposition Four argues for the essentially 'open' and contestable status of the research insights. Taken together these imply that research 'findings' can be appropriated by 'lay' actors. Such 'appropriation' involves the incorporation of research findings into the thinking of actors and, as action is concept-dependent, the conduct of actors is thereby changed. Laughlin (1991)⁹ discusses this in his analysis of 'second order' change or 'colonization' of a cultural milieu. Such a position recognizes that research has an intrinsic critical dimension, as all research has the potential to effect change and development. As Giddens (1984) has expressed it, 'the formulation of critical theory is not an *option*' (p. xxv; emphasis in the original). Therefore,

Implication Four: Hermeneutic research is intrinsically critical as, first, understanding must involve evaluation of actors' self-understanding and, second, actors may appropriate this evaluation and thereby change is enacted.

These four founding propositions and the implications derived from them are suggested here as a basis for the further development of hermeneutics in accounting research. The hermeneutic implications are shown in Table 2.

The following section continues by outlining how hermeneutics would impact upon research into the processes of change in management accounting.

How would the adoption of an hermeneutic methodology change the conduct and focus of current management accounting research?

This question is illustrated by reference to the ways in which two published empirical research studies—'The process of change in management accounting: some field study evidence' (Innes and Mitchell, 1990) and 'Accounting and organizational cultures: a field study of the emergence of a new organizational reality' (Dent, 1991) embody or deny the hermeneutic propositions and implications outlined above.

These two papers were chosen primarily because they were concerned with organizational change. Hermeneutics is particularly appropriate for the analysis of change as transitional periods reveal the mutually confirming relationship between systems of meaning and material practices. Under the circumstances of change what Bourdieu (1988) has termed the 'on-going struggle' for meaning intensifies and becomes more visible. Thus, in addition to the analysis of action for its sense-content

⁹Laughlin applies these ideas in his analysis of Dent's paper as an example of second order change in the railways.

Table 2
Hermeneutic implications

Implication One:	Researchers can legitimately offer accounts of events which either differ from or transcend the understandings of agents themselves.
Implication Two:	The research insights will be generated by the processes of projection and modification. They will reflect a synthesis of the frames of reference of the researcher and the researched.
Implication Three:	The interpretive research act is a creative endeavour whose inner coherence rests upon the starting point and boundaries which are imposed in the course of the research.
Implication Four:	Hermeneutic research is intrinsically critical as, first, understanding must involve evaluation of actors' self-understanding and, second, actors may appropriate this evaluation and thereby change is enacted.

and social significance, organizational change brings the nature of action as an 'open work' into sharp focus. The struggle for meaning also involves the establishment of referents as certain events are interpreted as key turning points in the production of new meanings and practices.

The Innes and Mitchell paper (1990) explores changes in costing practices observed in the competitive environment of the electronics industry. It makes no claims for an interpretive methodology but aims for a '... descriptive analysis of the *process* by which practical management accounting change has occurred at the level of the firm within a real world setting' (p. 4, emphasis added). The paper was chosen in order to illustrate the type of knowledge generated when processes of change are analysed through the following 'non-hermeneutic' assumptions: first, when independence is assumed between subject and object and, second, when it is thought appropriate to analyse changes in work practices in isolation from the changes in the meanings attributed to them. The assumption of subject-object independence is illustrated when the authors comment on the potential limitations of their reliance on the views of the management accountants (as interested parties) to the changes involved.

'Their views of management accounting changes....., of the origins of the techniques....., and of their consequences..... may reflect self interest *as well as reality* [emphasis added]. Alternative research designs perhaps involving more direct observation will help to ascertain whether the factors involved in management accounting change... are in accordance with the above analysis.' (p. 15)

Thus indicating the authors' assumption that access to an objective reality is dependent upon the use of correct *methods*. The notion that research must involve an *evaluation* of an actor's self-understanding (Implication Four) is by-passed by the assumption that 'more direct observation' will reveal whether or not the views of the management accountants were correct. Implication Two—that the research insights will reflect a synthesis of the frames of reference of the researcher and the researched is negated by the presupposition of an objective reality.

That the authors analyse processual change in work practices without reference to concurrent changes in meaning is demonstrated by their focus on the factors which are necessary and sufficient for change to occur.

'The first set of factors comprised conditions conducive to management accounting change which were necessary but not sufficient, in themselves, for the change to occur. Examples included the availability of adequate accounting staff and computing

resources. . . . These we have termed *facilitators*. The second set of factors. . . . included the competitiveness of the market, production technology and the product cost structure. These we have termed *motivators*. The third set of factors. . . . included the loss of market share, the arrival of a new accountant or a deterioration in profitability. These we have termed *catalysts*. Management accounting change occurred through the interaction of these three types of factor.' (p. 13, emphasis in the original)

Changes in meaning were seen as consequent upon change occurring. For example, the authors note that the organizational role and status of management accounting altered following the development of new management accounting practices (p. 13). Thus the hermeneutic assumption that change will always involve a 'struggle for meaning' is clearly not incorporated in the Innes and Mitchell analysis.

The theory underlying the paper is close to that of contingency analyses in its proposed identification of factors which have influenced management accounting change. However, the authors note some of the limitations of such work,

'... contingency theory provides only a static analysis of management accounting systems. . . . although. . . it. . . contributes to the identification of some of the factors which may drive change. . . . it does not explain *the manner in which this happens*. . .'
(p. 4; emphasis added).

Thus the authors are aware of the inadequacy of contingency theory as an explanatory framework for the processes of change. However, the explanation which they advance does not remedy these deficiencies because their analysis continues to split change into component parts (or factors) rather than showing how change is accomplished through human agency.

This paper is firmly rooted in the tradition of seeing accounting as a practical organizational resource. The authors identify the core areas of management accounting as, '... the timeliness and accuracy of costing information, the adequacy of financial performance measures and the practicality of operating a conventional control system' and consequently changes are anticipated in '... these fundamental areas. . . ' as managerial accounting change is '... designed to overcome the limitations of traditional practice' (p. 5). Such an account is congruent with what Hopwood (1987) has termed '... accounting change as a process of technical elaboration and, almost invariably, improvement' (p. 208). In methodological terms this research, although it is somewhat critical of contingency theory, adopts a stimulus-response model of how change is accomplished (p. 12) and different forms of accounting are seen as emerging as adaptations to changes in environmental circumstances (p. 9, 10, 11). Such a theoretical perspective has been characterized by Hopwood (1987) as depicting accounting change '... as a reflective rather than a constructive organizational endeavour' (p. 212). Therefore although semi-structured interviews were conducted with the management accountants the paper gives little feel for organizational change as a lived experience of sense-making for the actors concerned (Proposition One). Consequently the process of accounting change as a social accomplishment through human agency remains unexplained;¹⁰ there is little insight into '... how and by whom change is formulated and managed.' (Pettigrew *et al.*, 1992).

There is no discussion of how cultural and linguistic change accompanies and enables shifts in material practices and no pinpointing of those key events which actors

¹⁰ A glimpse of such processes is given when reference is made to a firm where the engineers had dominated management decisions and a quote from one of the management accountants recounts the rising ascendancy of accounting and accountants in the battle for information and resources (p. 15).

used to confer meaning on the unfolding story of change (Propositions Two and Three). What the paper does is give an account of those external (competitive market and economic recession) and internal (organizational restructuring, new product technology, incompatibility between cost systems and product cost structures, and managerial complaints about accounting complexities) motivating events which were cited by the accountants as constituting the origins of change. Thus there is knowledge of *why* accounting change occurred (in terms of the pre-conditions for change) but there is little insight into *how* change was achieved. Although the authors expand upon the factors cited above to include, for example, loss of market share as a catalyst for change and the existence of adequate accounting computing resources as a facilitator of change, no extension of this list of contingent 'variables' can ever ensure change as a necessary consequence of their existence as the authors imply (see quote from p. 13 above). The argument advanced here is that any research that hopes to fully illuminate the process¹¹ of management accounting change must work through an interpretive, if not a hermeneutic, methodology in order to demonstrate how change is accomplished through human agency.

The Dent (1991) paper traces the impact of new accounting practices on the organizational culture within the railways. This study explicitly adopts an interpretive methodology (p. 710) but such an approach is equated with the anthropological mission. Dent describes the aims of his research with a quote from Malinowski, 'to grasp the native's point of view, his relation to life, to realize his vision of the world' (p. 711). This perspective narrows the focus of Dent's research, effectively limiting his work to what has been described in this paper as Proposition One—the explication of the 'sense-content' of social action from the point of view of the actor/s concerned. Thus Dent's methodology, cannot encompass individual action as a social product both in its antecedents and its consequences (Proposition Two). The adoption of an hermeneutic approach here would have allowed Dent to expand his analysis to include the socio/political origins of the processes he observed. These may have been somewhat opaque to both the agents and the recipients of the organizational changes at the railways but such opacity does not necessarily exclude socio-political events from constituting the wider explanatory context for the material and cultural transformations at the railways.

Central to Dent's paper is a story: the story of the advent of a new breed of executive at the railways—the business managers. The business managers bring with them a new 'business' culture, a profit-oriented culture which is to challenge and overthrow the prevailing culture characterized by a preoccupation with engineering and logistics (p. 715). The 'old' culture—concerned with the railways as a social service is carried and reproduced by the 'old' guardians of the railways—the general managers.

Dent recounts the unfolding series of events at the railways through a narrative (Implication Three). His account of sense-making is congruent with Proposition One—that the 'sense-content' of action must be drawn out. 'Opinions, sentiments, interpretations, confusions. . .' (p. 712) were present in the interview data but these were made sense of by reference to the meaning of the situation to the interviewee. However, in contrast to hermeneutics, Dent equates meanings for interviewees with their role or function, their level in the hierarchy and the time of their interview

¹¹It is recognized that the Innes and Mitchell paper had an understanding of 'process' as the cumulative pressure for change engendered by moves from motivators to catalysts to facilitators but this paper would define these as the structural elements of change.

(p. 712). In his view, these three factors will determine the construction which interviewees place upon subsequent events. Hence, for Dent 'meanings' were identified with situational conditions at the railways. Such a position has been described by Dawe (1970) as '...postulating social norms as being constitutive *rather than merely regulative*, of the self' (p. 209, emphasis in the original). As is argued later, Dent implicitly argues, through his reference to the motives and intentions of the business managers, for a purely psychological theory of how change is enacted at the railways.

Proposition Three is evident in Dent's identification of referents, 'Some key turning points were obvious in the data' (p. 712). Dent identifies three key 'referential' decision points: the wider relocation of high speed passenger trains, the timing of the installation of new signalling equipment and whether train scheduling should be set to maximize operational or passenger convenience. The triumph of the judgements of the business managers in these decisions '...came to have a significance beyond the decisions themselves' (p. 721). These events escaped their initial circumstances to become focal points—in hermeneutic terms they took on non-ostensive references and, hence, became institutionalized within the railway culture.

'They were widely celebrated in the organization. . .and are recalled in explanations of the emergence of the business rationale for railway management. . .People used them to attribute a new meaning to their everyday activities' (p. 721).

Dent's research also gives an illuminating account of the interdependence of linguistic/cultural categories and material practices. Such an analysis both implies the possibility of institutionalization and points to Proposition Four—that social understanding is essentially open in nature.

'Prior to the study, the dominant culture . . . centred on engineering and production concerns . . . During the course of the study, a new culture emerged. The previously dominant culture was displaced by a new preoccupation with economic and accounting concerns . . . Gradually, through action and interaction, they were coupled to organizational activities to reconstitute interpretations of organizational endeavour' (p. 708).

Such an institutionalization process has been described by Berger and Luckmann (1967) as the accumulation of 'linguistic objectifications' (p. 56). These meaningfully order all the routine events encountered in everyday life. Dent's study shows how the objectifications of the language of engineering and logistics were supplanted by those of accounting and economics. Such a change is a very powerful one, for as Berger and Luckmann point out '...everyday life is dominated by the pragmatic motive' (p. 56) and once everyday reality at the railways is defined in terms of accounting and economics the previous reality constituted by engineering and logistics fades into the background and is 'forgotten' as events are made meaningful within the world of a business reality.

The story of the coming of the business managers gives an account which portrays these agents of change as determined in intent but, at first, unsure as to how change can be achieved.

'The story is one of evolving interpretations, meanings and perceived possibilities. No one in the organization foresaw the outcome at the start, not even the business managers' (p. 715).

Such an approach is hermeneutic in its understanding of change as historical, developing and concept-dependent (Propositions Three and Four, and Implication Four)

What Dent's research lacks is any understanding of the motives and actions of the

business managers as social constructions (Berger and Luckmann, 1967; Neimark and Tinker, 1986; Hopper *et al.*, 1987). The business management initiative itself is dissociated from wider socio-political developments.

'But such evidence as is available supports the view that the initiative was developed largely independently of political ideas, its private sector leanings owing more to the advice of a few business consultants than to any political agenda. Certainly it was not government-inspired; indeed government was initially sceptical, only later endorsing the ideas (and applying them to its own ends' (p. 728)).

If the events recounted at the railways were disengaged from the broader socio-political context then a gap appears—how can the actions of the business managers be understood?

In response, it seems that Dent's research must rely on a psychological theory of how change was enacted at the railways.

'Equally important are the personalities and backgrounds of the business managers . . . these men became evangelists, hungry people with a mission. They developed a zeal to convert the railway from a social service to a business enterprise.' (p. 716).

If, initially, the business managers were fired with ardent evangelical intent, later their 'hunger' took a more tangible form as the metaphor of the hunt enters Dent's analysis.

'These Regional Business Managers, once appointed, carried the economic perspective deep into the regional organizations, carving underneath the regional General Managers and giving Business Managers a direct line of influence to operational activities. One commented: "People in the regions are used to doing things without asking. They find themselves subject to our scrutiny. I can take things up in a big way, if necessary, and howl for their blood".' (p. 720).

The point here is not to challenge the authenticity of the self-understanding of the Business Managers as predatory agents of change. Other research confirms that metaphors of seduction, of the chase and of the hunt are common as actors attempt to reconstruct and explain to themselves (and others) the course of what they see as crucial and dramatic events (see Bryman, 1989). Nor is it denied that the drive and energy of the business managers was necessary for change to be enacted. Is it sufficient, however, for Dent to uncritically accept these subjective interpretations as encompassing understandings and conclude that the changes at the railways were driven purely by the cumulative dynamic of the inner drives of the Business Managers?

The argument here is that, in this, Dent is restricted by his chosen methodology. His understanding of the interpretive endeavour is that it, 'Necessarily, . . . precludes the imposition of exteriorized accounts and radical critique.' (p. 710). But as Levi-Strauss (1969) indicated it is important to show, '. . . not how men think in myths, but how myths operate in men's minds without their being aware of this fact. . . .' (p. 12). 'Exteriorized accounts' must form a part of the analysis of the antecedents of action as some antecedents are opaque to agents. Otherwise interpretive research will be reduced to what Garfinkel (1967) terms 'accounts of accounts'.

As others [see Boland (1989) for a discussion of how hermeneutics can close the subjective-objective gap] have pointed out, an interpretive hermeneutic approach to research can integrate subjective understandings with an analysis of the objective conditions for social action which simultaneously enable and constrain individual endeavour (Proposition Two and Implications One and Four). When the interpretive

task is limited to the explication of subjective understandings then critique is marginalized but this is contingent upon a limiting definition of interpretivism as a methodology. As Willmott (1983) and Hopper *et al.* (1987) show, interpretivism can be extended from its micro-processual focus to encompass a critical dimension. In short, Dent's paper provides an instructive and illuminating account of *how* change was brought about at the railways, but its analysis of *why* organizational change occurred remains at the level of individual psychology.

The contrasts afforded by these two papers show that the type of knowledge generated by research is not primarily linked to methods (as both were case-study based and used semi-structured interviews¹²) but flows from the research methodology. The scenarios investigated were not dissimilar. Both studies were concerned with the process of change in organizations. Both organizations faced turbulent environments. In the Dent study 'The railway was under acute threat. The competence of public-sector management was openly under challenge.' (p. 715). In the Innes and Mitchell study the electronics industry faced extremely keen international competition (p. 4). Both organizations were characterized by internal power struggles—between the business managers and the general managers (Dent, 1991) and between the engineers and the accountants (Innes and Mitchell, 1990). Yet the knowledge produced by the studies was strikingly different in content being dependent upon that 'rock-bottom antinomy'—namely the opposition between subjectivism and objectivism. This paper would argue that the limitations of both these papers could be transcended by integrating '... the analysis of the experience of social agents and the analysis of the objective structures that make this experience possible.' (Bourdieu, 1988, p. 780, p. 782) As argued earlier, hermeneutics offers some methodological answers to the subjective-objective dualism through its emphasis on action as a social product—Proposition Two [see also Boland and Pondy (1983) and Boland (1989)]. Thus overcoming the limitations introduced when action is seen either as the outcome of consciously pursued goals (cf. Dent) or the result of mechanical determination by external causes (cf. Innes and Mitchell).

3. Conclusion

This paper has sought to re-establish a convergence between the empirical and the interpretive traditions in management accounting research. As reflection upon the two papers cited above illustrates, accounting research needs a strong on-going programme of empirical work in order that theory is constantly generated, challenged and re-worked through exposure to processual change. To assert that theory construction and empirical work need to proceed together in order to address a research agenda which acknowledges and encompasses change does not deny that theory and empirics are conjoined—such conjunction stemming from the inevitably context-bound nature of understanding. This is eloquently stated by Bauman (1978):

'Any intellect, however powerful, sets about its work loaded with its own past; this past is simultaneously its liability and its asset. Thanks to its past, the intellect is able to see; because of it, it is bound to remain partially blind.' (p. 225)

¹²The ways in which the two studies extended their research were, however, different. The Dent study was an in-depth longitudinal analysis whereas the Innes and Mitchell paper was cross-sectional in its look at seven different sites. The time span of the two studies was, however, similar—being around 2 years.

Hermeneutics has a 'way of seeing' (constituted by its methodology), and through its integration of the subjective and objective realms of experience it can focus what to 'look at' but it cannot resolve the dilemma that any research picture will be a partial one—such a conclusion is inescapable given the premises of interpretive work. The only circumstances which would allow the emergence of complete understanding—the existence of a closed system—would not require interpretation or understanding but would only call for explanation (Bauman, 1978). The partiality of any interpretation will reflect three facets of hermeneutics. First, the unique engagement of the frames of reference of the researcher and the researched—what Gadamer has termed a 'fusion of horizons'. This fusion allows 'the world of the text' (Ricoeur, 1981, p. 111) to be opened up. What is disclosed is not the world 'behind the text'—the hidden intention of the author—but the world 'in front of the text'—all those things which the author could have been aware of but, by design or default, was not (Bauman, 1978, p. 229). Second, the starting point and boundaries imposed on the interpretation (enabling a meaningful totality to be constructed from a series of scattered events) will be unique to the researcher. Third, the historical context which forms the setting for the interpretation, and, in relation to which it makes sense, renders any account an artifact of its time and hence intrinsically transitory.

The fact that meanings will change with the 'world' of the researcher does not imply that interpretations are never consensual. For any fixation of the context ensures that meanings are not usually contested (Fish, 1979). Being in a situation means that a particular context will be assumed. As Dent's study showed, when the context for the operation of the railways was constructed around engineering and logistics, there was consensus on meanings. Only the advent of the business managers introduced an alternative context—that of accounting and economics—and only with an alternative context did meanings become disputed (opening the way for changes in practice). The existence of the dominant 'pragmatic motive' (Berger and Luckmann, 1966) in everyday life ensures that whilst a context, culture or 'way of thinking' allows agents to 'go on' (Giddens, 1984) in their work it is likely to continue. Alternative contexts, cultures or 'ways of thinking' have to be construed as more successful, in terms of their practical interventions in the world, in order to supplant the current orthodoxy. Research is no different, in this respect, from any other realm of work. Hence although positivist orthodoxy presenting the researcher as someone with a '...very polished, non-distorting mirror for a mind' (Madison, 1990) has been eroded, interpretive accounting research has, so far, lacked a conception of how the values and beliefs of the researcher shape the research process. This paper has sought to remedy this.

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Managing the Boundary

How Accounting Is Implicated in Maintaining the Organization

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Introduction

Organization is a form of social life, yet it is a particular form which is, in many ways, clearly differentiated from wider society. The concept of the organizational "boundary" captures the nature of this differentiation (or separation) first, by defining, through processes of inclusion/exclusion, the limits of the organization as it "meets" its environment and, second, by maintaining the the organization as a unified entity. Thus the notion of the organizational boundary contains a contradiction. The boundary marks a separation but, paradoxically, such a separation "...creates the perception of something that is also whole or unitary" (Cooper, 1989, p. 488). The article will expand on the dual nature of the organizational boundary by considering boundaries as "thresholds" and as "binding structures". This distinction also relates to the ways in which accounting is implicated in boundary maintenance, for the article will argue that financial accounting is, in the main, concerned with establishing "thresholds" while management accounting is, primarily, involved in the reproduction of "binding structures". One catalyst for change in organizations, and in their accounting practices, occurs when tensions are engendered through the simultaneous pursuit of separation and integration. The disruption and reconstitution of boundaries in such transitions are considered with reference to case studies of accounting change.

Boundaries can be defined in a number of different spheres of organizational activity. The physical/productive, financial, psychological, legal and temporal realms are all areas where boundaries are represented. The boundaries of the organization in physical/spacial terms are co-terminous with its buildings (in their geographical layout), with its employees and with those departments (such as sales and marketing or research and development) which interface most directly with the environment. In the productive sphere boundaries are represented by the extent of equipment, labour power and physical output or product. In psychological terms the limits of the organization are defined as all those elements (role, culture, symbol and ritual) which demarcate the distinctive nature of organizational life. The boundary between the organization and society being experienced most directly by individuals as the division between their public and private lives. Temporal boundaries are achieved by dividing time into ordered sequences in order both to structure working practices

and to provide for formal/informal periods. Highly pertinent to the formal organization are those agencies and artefacts which document the limits of the organization in legal and financial terms. This article has a primary emphasis on the financial boundaries of the organization and explores the ways in which accounting is implicated in forming and managing these boundaries.

Despite the potential contribution of boundary maintenance ideas it is only recently that organizational theory has begun to formulate the concept of boundary management as an essential organizational activity. Within this way of thinking the identities of the organization and its environment are established and maintained through a process – a crucial element in any achieved organizational identity being the perception of it as an ordered, rational place (Cooper, 1990). Thus, the article begins by looking at how the idea of boundary maintenance as an achieved phenomenon was by-passed by the notion of the universal, rational, ordered organizational form. It continues by examining empirical evidence of the changing organizational context of accounting, changes which resulted in more organizational “surface” being exposed to the external environment. The notion of boundary maintenance emerged then as the “closed system” perspective in organizational theory and gave way to ideas on “open systems”. Having introduced the concept, a discussion follows on how accounting is implicated in maintaining boundaries, first, as thresholds and, second, as binding structures. The article concludes by assessing the consequences of boundary maintenance ideas for the relationship between organizational and social theories and for the role of accounting.

The Assumption of the Rational Ordered Organizational State

Defining the distinctive nature of organizational life has been a dominant theme in organizational theory since the work of Max Weber. Weber predicted that the inevitable rationalization and disenchantment of the modern world would crystallize in universal bureaucratic forms. Furthermore the technical superiority of these forms would ensure that they became constituted as defining organizational characteristics. Such forms would endure “...because it is only through the purposefulness and goal directedness of organization that the uncertainties of disenchanted modernity could be coped with” (Clegg, 1990, p. 33). Hence the expectation was that, in a disenchanted world, the reassurance derived from “calculability” would replace the sanctity of ultimate values, as forces for rationalization created organizations as “ordered places”.

Weber as *the* theorist of modernity (Reed, 1993) had articulated themes which proved to be extremely influential. Organizations were seen as:

Islands of rationality in a sea of human irrationality: their triumph over the surrounding environment assured by their vastly superior technical capacity for co-ordinating and controlling the individual actions of millions of human beings (Reed, 1985, p. 5).

This view dominated organizational theory up to the 1970s. Writers as diverse as Habermas, Foucault[1] and Perrow were, nevertheless, united in a common

assumption of the universal logic, and, hence, self-sustaining nature, of the bureaucratic organizational form. Habermas conceived of organizations as self-regulating technical mechanisms co-ordinated around the goals of money or power. Such systems tend to colonize and erode the cultural "life-world" which gives meaning to life and work – thus yielding supremacy to rational-technical configurations. Foucault continued the theme of the pervasive nature of the bureaucratic form by exploring how the time-space dimensions of modern bureaucracies allowed the surveillance and control of even the most mundane of working practices. Perrow expressed the uniformity inherent in bureaucratic hierarchies as a moral principle. The morality of bureaucracies lying in the guarantee of equal treatment for all organizational members of the same status regardless of their social, racial, sexual or religious identities. But the inevitability of the bureaucratic form (as an expression of human rationality) was the underlying theme of all these analyses. In bureaucracies division of labour and hierarchical control structures are spelt out in formal rules and cultural rationalization is monopolized by the organization – hence bureaucracies control their own definitions of reality (Meyer, 1986). Thus, given this rational-legal-technical organizational form, active processes to continuously achieve organization as an unambiguous state were unnecessary. Yet although formal organization is a defining feature of the present world, real bureaucratization, as envisaged by Weber, has made but a "weak advance" (Meyer, 1986). Hence the expectation that organizations can self-evidently be differentiated from society by their universal conformity to rational-bureaucratic models has not been realized.

The development of natural systems theory (Scott, 1981a) was one response to evidence that the iron-cage of bureaucracy did not encompass all organizational forms. Natural systems, through a focus on the individual within the organization, made visible all aspects of organizational life where no clear distinctions existed between organizational and socio-political processes. A fundamental assumption of such theory was that "people, social life, language, interactions and interpretations are just as human inside organizations as they are outside" (Turner, 1990). From such a perspective the concept of a unified system designed for goal congruence is negated by the existence of interest groups or informal coalitions in pursuit of disparate aims. Corporate culture and interpersonal relationships prefigure problem construction, and decision making is more closely aligned to political processes of interaction and adjustment than it is based on cause-effect or cost-benefit calculations (Boland and Pondy, 1983). If the rational perspective tends to disconnect the organization from society the natural perspective presents the organization as a microcosm of society. One way of avoiding this dichotomy is through the use of Thompson's (1967) conception of organizations as systems, which by reducing or absorbing uncertainty achieve rationality – albeit of a limited kind.

On a theoretical level a conception of the organization as a system which reduces or absorbs uncertainty opens the way for a focus on the means whereby uncertainty is managed. Thus, Thompson's concept of the organization was a natural precursor of boundary maintenance theory as boundary activity is primarily directed towards reducing uncertainty. On an empirical level the organizational context of accounting was also changing as vertical integration through hierarchies gave way to the problems engendered by managing more diversified organizational forms.

The Changing Organizational Context of Accounting

The nature of the organizational context of accounting is in transition as modern gives way to post-modern organizational forms. The key theme of post-modern organizational theory being what Power (1990) has termed as an "assault on unity". New alliances such as private-public partnerships, joint ventures and mergers are challenging the notion of the organization as a "systematically bounded" entity functioning as a "single centre of calculation and classification" (Clegg, 1990, p. 19). Evidence is accumulating on new inter-organizational linkages and on new intraorganizational forms[2]:

- (1) The post-modern organizational structure has a flatter hierarchy, is more fragmented and decentralized, and less formal and less bureaucratic than its modernist predecessor (Graham, 1989).
- (2) Post-modern organizations are more responsive to Mintzberg's (1983) "external coalition" or "cast of players" (owners, suppliers, clients, partners, competitors, unions, professional societies, newspaper editors, governments and special interest groups) who "frame" the organization.
- (3) Production in a post-modern organization tends to be flexible, FMS enabling organizations to go for market niches rather than (or as well as) mass forms. Production is organized around technological choices rather than driven by technological determinism, and functions through multi-skilled rather than de-skilled jobs (Clegg, 1990, p. 181).
- (4) As more flexible network-based configurations replace hierarchies with a "... resulting 'shrinkage' of the middle layers..." (Thompson, 1993, p. 185), management processes take place "horizontally" across organizational sub-units rather than "vertically" through a well-defined chain of command – mechanisms such as profit centres, subcontracting and quality circles contributing to the decentralization of production decisions (Thompson, 1993, p. 190).
- (5) Shifting patterns in the ownership of managerial control systems are also apparent as post-modern organizational forms, more sensitive to consumption rather than production issues, emerge. Once production began to be successfully routinized, managerial power passed from production to sales and marketing as "... extending market penetration

and developing innovation through product-related strategies" (Clegg, 1990, p. 97) began to be conceptualized as the key issue for organizational success.

- (6) Information, computerization and knowledge assume primacy as the driving forces for innovation in post-modern organizations – thus implying highly developed organizational search and scan capabilities.

For these reasons post-modern organizations have more "surface" exposed to the external environment (Graham, 1989). There are, therefore, both theoretical (see the previous section) and empirical imperatives which direct post-modern organizations and post-modern organizational theorists actively to address the issue of boundary maintenance.

Conceptualizing Organizational Boundaries

This section considers how the concept of the organizational boundary changes with shifts in organizational theory. It examines:

- closed systems theory;
- open systems theory; and
- active boundary maintenance.

The Boundaries of Closed Systems

Classical management theory conceptualized organizations as "closed" systems whose "goals" were achieved through principles of internal design which minimized uncertainties arising from the interdependence of component parts (Hayes, 1980). Scientific management and administrative theory produced universal prescriptions for organizational design. Thus, Taylorism was geared towards minimizing uncertainties arising from the "general purpose" nature of people by transforming them into "specific purpose" employees (March and Simon, 1958, p. 13). In turn, general management theory addressed administrative problems of co-ordination and control flowing from the uncertain nature of intraorganizational interactions (Fayol, 1949). Such systems were portrayed as relatively impermeable to their surrounding environments and therefore became theorized as self-sustaining entities which are "conceptually detached" (Cooper, 1990) from their backgrounds. The machine constituted the overarching organizational metaphor for these closed systems (Morgan, 1986) and the mechanized bureaucracies most closely conformed to organizational models designed and operated as machines. Attention is focused on the assumed unity of the system and hence the *ongoing processes* through which that unity is maintained remain unexamined. Conceptually the boundary of the system is marginalized and remains "at the margin" as a "... kind of container which holds the system parts together and thus prevents their dispersal" (Cooper, 1990).

The Boundaries of Open Systems

In contrast “open systems” theory recognizes the importance of interactions between the organization and society (by seeing organizational boundaries as permeable) and introduces the idea that the survival of the system implies an appropriate relationship with its environment (Morgan, 1986, p. 45). However, this relationship takes the form of *adaptive* responses to the threats and opportunities which arise in the environment (Gouldner, 1959). Hence the idea of *active* boundary maintenance as an essential feature of organizational life is still relatively neglected. In contingency theory, for example, the outer organizational context is acknowledged but it is “... conceptualized as an environment comprising a variety of factors that must be registered and controlled if strategic adjustments are to be successfully achieved” (Willmott, 1990, p. 45). Central to contingency analysis is the pursuit of equilibrium, as “adjustments” harmonize structural and contextual “variables”. The analysis presents a static picture of organizations, change being enacted through processes which are seen as essentially aberrant in nature and as ceasing once stability is regained. Thus, equilibrium is privileged over boundary activity rather than being conditional upon boundary maintenance. As contingency analyses assume that functional imperatives determine organizational restructuring, they cannot encompass the active accomplishment through agency of the organization as an embedded, but differentiated, part of wider society. The organization as an organic entity evolves “... on the basis of an *independent* social logic which ... can ... be internalized by its members” (Reed, 1985, p. 27, emphasis added). However, from the open systems perspective, the organizational boundary is more than an outer shell of containment, its essential feature being the permeability which allows input-output flows as materials, energy and information are exchanged between the organization and its environment. But inside-outside distinctions remain a priori – certain characteristics are “... inexorably naturalised as being *inside* the organization, such as ‘size’ and ‘technology’ ... “whereas” ... those factors *outside*, such as the ‘environment’ have a precarious contingent relation to these interior forces” (Clegg, 1990, p. 19, emphasis in the original).

Boundary Maintenance as an Essential Organizational Activity

Fundamental to boundary maintenance theory is the idea that “we are no longer looking at something that an organization ‘has’, but at the processes that make it possible for an organization to exist at all” (Turner, 1990, p. 87). Organization becomes an appropriation of order from disorder and, in this appropriation, the boundaries or “surfaces” of a system constitute those areas of greatest potential instability (Power, 1990). Thus, boundary management constitutes the *achieved* relations of “relative autonomy” and “relative dependence” which exist between organizations and their environments (Clegg, 1990, p. 7). From this perspective boundary maintenance is an organizational problem and specific individuals or

agencies will pursue strategies to achieve it. Boundary management, as an organizational task, is, most usually, accomplished by people in either liaison or leadership roles:

By monitoring and controlling boundary transactions people are able to build up considerable power. For example, it becomes possible to monitor changes occurring outside one's group, department, or organization and initiate timely responses... Or one gains access to critical information that places one in a particularly powerful position to interpret what is happening in the outside world, and thus help define the organizational reality that will guide action (Morgan, 1986, p. 169).

But while agency is central to this account of boundary activity, such agency is not only accomplished through the reasoned intentions and capabilities of purposeful individuals:

Agency wreaks its action on the world through the attempted accomplishment of projects which make sense in terms of the *forms of calculation* which agents have available to them (Clegg, 1990, p. 7, emphasis added).

Through such "forms of calculation" all organizations have built into them a "mobilization of bias" (Giddens, 1984, p. 15) which means that power does not reside purely with the capabilities of individuals[3]. Thus, what agents know is "...not purely idiosyncratic but is institutionally framed" (Clegg, 1990, p. 13). Hence the role of institutionally generated information, such as accounting, is crucial to the task of boundary management.

To summarize, boundary maintenance theory describes organizational boundaries as achieved by individuals (or collective agencies) as they filter and process information to maintain an organizational identity in both physical and conceptual terms. In comparison to the "closed" and "open" system approaches more organizational surface is assumed and consequently more organizational/societal interdependencies are recognized. Such interdependencies are conceived not as objectively established "threats and opportunities" but as reflecting the dependence of any environmental understanding on the organization's self-understanding. Thus, organizational boundaries constitute those areas where the process of organizing occurs. Such processes involve inclusion and exclusion as an organizational identity is maintained and the organization enacts its environment.

Figure 1 captures the differences between closed systems, open systems and active boundary maintenance theories for the concept of the organizational boundary.

How Accounting Information Is Implicated in Boundary Maintenance

One of the arguments of this article is that, at a fundamental level, organization has to be achieved. Information is integral to the process of organizing:

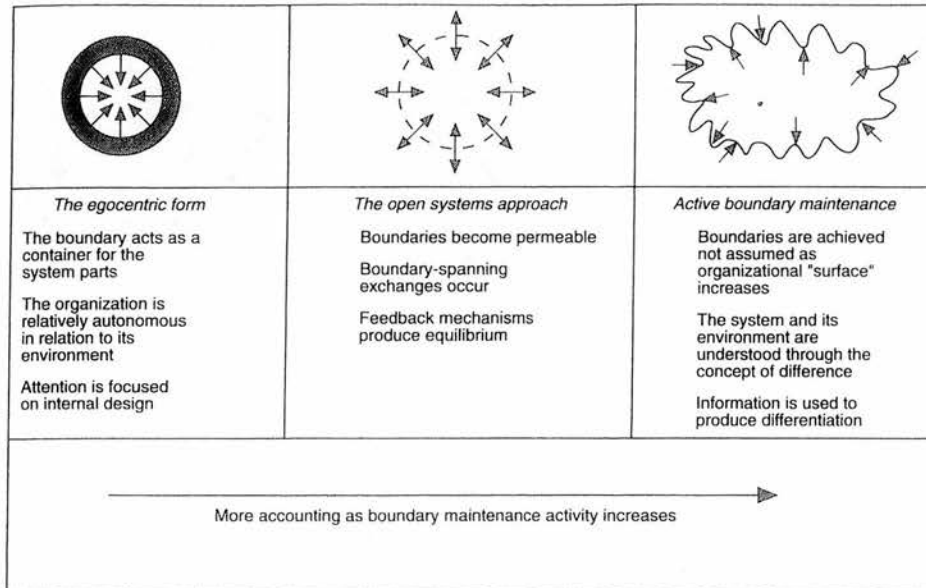


Figure 1.
Differing Conceptions
of the Organizational
Boundary

The role of information is to mediate between form and matter, order and disorder; information is a process (and not a state) in which form is made out of non-form (Cooper, 1990, p. 172).

Institutionally generated information, such as accounting, is pivotal for both productive activities and communicative interaction. However, accounting information also absorbs uncertainty, shapes expectations, and makes some organizational activities more visible than others. But accounting is only one of a number of information flows in organizations. Under what circumstances, therefore, does accounting begin to predominate over other information systems in the process of managing boundaries?

The next three sections address this question by first, presenting financial accounting as a "threshold" device which manages the boundary between the organization and its environment, second, by linking management accounting with the "binding structures" which preserve organizational unity[4], and, third, by considering how boundary tensions engender processes of change.

Boundaries as Thresholds

Financial reporting charts the physical/spatial and financial limits of the organization through the quantification of assets and liabilities. Therefore, it defines, through processes of inclusion and exclusion, the boundaries of the organization as a physical, legal and financial entity. Various uncertainties, other than those of a technical nature, are posed by this exercise. The inclusion/exclusion of intangibles, such as goodwill, involves the management of conceptual and measurement uncertainties. The drawing of financial and

legal boundaries also has considerable ethical implications. Decisions on the inclusion/exclusion of environmental pollution or the consumption of natural resources and infrastructure (such as water and roads) have moral dimensions (Francis, 1990). Such financial accounts define the limits of both modern and post-modern organizations in physical, legal and financial terms and would be acknowledged by closed and open systems theory – such accounts fulfilling the core “institutionalised expectations” (Zald, 1986, p. 330) which have arisen around accounting. But post-modern organizations are characterized by the “...relative shift from commodity production to service delivery and intellectual technologies ...” (Heydebrand, 1989)[5] and within the service industries (and the reduced manufacturing sections) functionally flexible organizational forms with dispersed centres of power and heightened reliance on information for control. The argument here is that under these conditions of greater differentiation and increased organizational/societal interpenetration reliance on traditional accountings will no longer be sufficient to maintain thresholds in post-modern organizations.

Classic organizational theorists anticipated the expansion of accounting in line with increased differentiation (Blau and Schoenherr, 1971; Perrow, 1979; Scott, 1981b). Meyer (1986) comments on this and goes on to tie the requirement for more accounting with an enhanced need for co-ordination and control as organizations become characterized by increased technical activity. However, within this way of thinking, the crucial determinants of accounting activity lie *within* the organization. More germane to the idea of “thresholds”, however, is Meyer’s proposition that demands for accounting can also arise in the environment – that accounting also increases in response to pressures from *outside* the organization. Meyer considers two possibilities:

- (1) That the environment presents problems or opportunities with which the organization must contend. Hence the environment makes demands on the organization (here he cites the expansion of capital markets as a major determinant in creating more financial reporting).
- (2) That the environment supplies cultural materials or resources, such as accounting, for organizations. Organizations that utilize these “culturally sanctioned” resources are thereby legitimized both internally and externally. This second argument is highly pertinent to ideas about boundary maintenance for here accounting is central to the management of meaning between the organization and society – accounting acting as a legitimating institution (Richardson, 1987) for organizations.

Predictions about the prevalence and visibility of accounting and accountants can, therefore, proceed from evidence of increased rationalization of particular institutional sectors of society. Meyer (1986, p. 348) cites the example of health care where, at the macrosocietal level, increased rationalization has resulted in heightened legitimacy for those medical organizations where there has been a significant expansion in accounting work.

The present scenario in the UK provides an illustration of this. For many years in the National Health Service financial reporting practices in the NHS were aimed at demonstrating compliance with statutory directives – for example, the prescriptive guidance on accounting from the Department of Health for cash expended by the health authorities (Lapsley, 1992). Statements of income and expenditure had the primary aim of determining whether health authorities had met their financial objectives (i.e. had spent no more than their yearly allocations). Thus, “thresholds” were maintained primarily through legalistic means, and traditional accountings sufficed to establish boundaries between the NHS and its main regulator – central government.

However, social, technological and political changes converged to undermine the organizational legitimacy of the NHS. Such pressures disrupted reliance on the limited nature of accounting as practised for most of the life of the organization. An unparalleled expansion in expensive medical technology, a focus on scarcity rather than resource allocation, and some erosion of the autonomy of clinicians combined to place the value of health care, as a product, in dispute (Llewellyn, 1993). Once health care becomes commodified in this way accounting tends to expand. It provides the monetary values (i.e. costs and prices) which by spanning organizational and societal cultures can be used to restore legitimacy when greater organizational/societal interpenetration has occurred. Thus, when medical organizations become more open to societal scrutiny more accounting can restore thresholds which reclaim rationality and order for the organization. Those organizations, such as the NHS, facing uncertain goals (perhaps with long time horizons for goal accomplishment) or having indeterminate input/output transformations are particularly vulnerable to societal pressures for increased legitimacy (Dirsmith, 1986, p. 360). Such organizations will tend, therefore, to be more reliant on accounting for boundary maintenance.

Such a boundary maintenance strategy will, however, entail a high degree of risk. Traditionally, health organizations have been legitimized by the processes they incorporate rather than the products they supply – the worth of such institutions being arrived at by reference to internal definitions. Thus, patients have been referred to particular hospitals because they offer a credentialled or medically regulated service – referrals have not been dependent on judgements on outcomes for patients. Historically, in health organizations, criteria for the evaluation of products or outcomes, as distinct from the processes of delivery, are lacking. Consequently, the process itself becomes identified with the product (Heydebrand, 1989). But for accounting to legitimize medical care a product must be defined. In health care the “treated case”, as a product, although not allowing for any evaluation of outcome, permits the attachment of a monetary value (cost or price) to a distinct health commodity. Exchange values then facilitate comparisons on costs (or prices) between different institutions. Such cross-institutional comparisons will, however, create a potential “winners and

losers" scenario. Hospitals are not only required to offer a professionally recognized and regulated service, but to demonstrate cost efficiency *vis-à-vis* peer institutions. Thus legitimacy, via accounting as exchange value, is inherently more precarious than legitimacy conferred through formal rules for process. Nevertheless once legitimacy via internal rule structures becomes challenged, organizations will draw on accounting as a legitimizing artefact which is congruent with the values of a society where health care has become commodified. An expansion in accounting (which in the case of the NHS involved a more commercial format for financial accounting and a greater emphasis on management accounting for the pricing of services) will then restore a rational, ordered identity and the organization can again achieve a form of closure in relation to the society in which it is embedded.

Boundaries as Binding Structures

Boundaries not only function as thresholds; they also, by acting as binding structures, produce and reproduce the internal unity of the organization. Internally the boundaries of an organization bind organizational time and space or create "time-space zones" (Giddens, 1987, p. 148). Such zoning enables mastery over the diverse productive, social and political processes which organization embodies. The attention-directing, performance-monitoring and information coding functions of management accounting contribute to time-space zoning by reducing, absorbing or denying the uncertainty which is endemic to organizational life. Central to these accounting functions is writing as "... the process by which human agents inscribe organization and order on their environments" (Cooper, 1989). Accounting embodies and has capitalized on two critical features of writing: first, that information is available "at a glance" and, second, that it appears in a "depersonalized" form – such features acting so as to promote perceptions of accounting as free from "contamination by undecidability" (Cooper, 1989, p. 500). Accounting thus reduces indeterminacy through the organization of time/space and within these processes both "accounting as history" and systems of accountability are pivotal.

The "backwards-looking" aspect of accounting is critical in forming the authoritative organizational history which can be used to shape the future. Accounting rules constituting legitimized guidelines for "... the construction of a representation (pattern, picture, model) ... of the world" (Mackay, 1969, quoted by Cooper, 1992). The processes within accounting directed towards ensuring factual, authentic and true reports lend considerable credence to the use of accounting as history, for system monitoring and for the guidance of future conduct (Chambers, 1989). A framework for accountability provides both for the monitoring of system reproduction and for the definition of the limits of the application of the system:

Accounting involves the binding of organizational space in the very real sense in which one of the most important boundaries of an organization is defined by the boundaries of its system of accountability. To be part of an organization is to be subject to that organization's system of accountability: a customer is not accountable to someone within the organization, in the same

way that an employee is accountable. Within these boundaries the physical organization of space in terms of hierarchical, functional and divisional patterns are not just reflected in, but are also reproduced through the operation of systems of accountability (Roberts and Scapens, 1985, p. 448).

An example of boundary changes to systems of accountability is provided by Tai (1990) in a case study of the "new managerial ideas" as expressed by the Industrial Structure Council of the Ministry of International Trade and Industry (MITI) in Japan, and adopted by the giant Japanese electrical equipment conglomerate Matsushita Electric. The "new managerial ideas" culminated in a plan to establish a "corporate civil society". Such a plan involved the extensive rethinking of the boundaries between Matsushita and society, as the following description of the "corporate civil society" demonstrates:

A system in which the people work together toward attainment of public targets and values shared on such different social levels as within each enterprise, between enterprises, between enterprises and society, and between enterprises and consumers, instead of leaving the behaviors of the enterprises up to the private market mechanism (p. 54).

One facet of the proposed reconstitution of organizational boundaries was a recasting of the relationship between Matsushita and the subcontractors who supply a very high number of the essential component parts for electrical equipment. Matsushita wished to reduce their dependence on these subcontract firms and the intent inherent within the statement of the "corporate civil society" provided a rationale for doing so. A focus on the mutual benefits of shared values allowed Matsushita to take "an increasingly stern attitude" (p. 61) towards those firms which continued to operate as independent units. In order to bring these recalcitrant subcontractors into closer collaboration with the Matsushita division the standard time allowances within Matsushita's standard costing system were also applied to the independent subcontract firms. Thus, the boundaries of the systems of accountability were successfully extended to reduce the autonomy of independent units and such firms are now "bound" by accounting numbers in a managerial relationship of much tighter surveillance and control.

Systems of accountability also permit the co-ordination and control of intra-organizational superior-subordinate relations where people are physically at a remove from one another. The potential for the assertion of subordinate power is reduced when accounting rules delineate expected procedures and results. Thus accounting, through "action at a distance" (Hopwood, 1990; Robson, 1992), can enable the integration of organizational sub-units and the long-distance control of subordinates. Systems of accountability reproduce an organization which is, physically and psychologically, more cohesive and coherent. Also, by creating reciprocal rights and responsibilities, they bind organizational members together and go some way towards banishing the potential disruptive influences of race, class and gender from the organizational arena:

Systems of accountability also embody a moral order: a complex system of reciprocal rights and responsibilities. The practice of accountability institutionalises the notion of accountability; it institutionalises the rights of some people to hold others to account for their actions (Roberts and Scapens, 1985, p. 448).

Thus, the boundary of the organization also marks out a space within which particular rules establish contractual relationships – the boundary symbolizing the moral unity of the organization where an assumed common purpose absorbs social tensions by binding together the separate goals of all organizational members.

Closely associated with spatial zoning is the ordering of time as agents organize the “setting” of their action. Accounting is presented as one of the ways in which time can assume limits and be standardized:

Accounting structures organizational time by dividing the flow of organizational life into “accounting” periods and generating regular reports, budgets and appraisals with all their related practices (Roberts and Scapens, 1985, p. 448).

It provides “rites of passage” such as the year end when particular attention is paid to the relations between the past and the present and the risks associated with the future. Future uncertainty can be reduced by the attachment of rates of return to future projects as “chunks” of future time are then accounted for. Accounting also enables the commodification of time as monetary costs are attached to both labour and machine time. Although the commodification of time, as a practice, is still uneven, the period during the 1980s saw an extension of the costing of time from productive and service industries to the social services as, for example, teaching and medical care became much more commodified (Clark, 1990).

Thus, accounting constructs particular forms through which information can be represented (Cooper, 1992). The “particular forms” of organizational histories, systems of accountability, moral codes and temporal ordering which accounting produces facilitate the binding of organizational space/time and, thus, maintain the organization as an entity.

Shifting Boundaries and Boundary Tensions

The preceding sections have expanded on the metaphors of “thresholds” and “binding structures” in boundary maintenance. Financial accounting has been portrayed as a “threshold” device which manages uncertainty on the boundary between the organization and society. Management accounting has been seen as implicated in the reduction of internal uncertainties and, hence, in the reproduction of the organization as an entity.

The simultaneous absorption of both internal and external uncertainties is often problematic. This section explores how boundary management is tied up in processes of change in organizations. In particular it examines a situation in which there is an organizational focus on one source of uncertainty to the neglect of another. The 1985 Berry *et al.* study of the National Coal Board (NCB)

provides a useful example of such a scenario. During the period of time that this study took place control mechanisms at the NCB were loosely coupled. Such loose coupling effectively insulated one part of the organization from disturbances that were occurring in another (p. 4). Thus, rather than management accounting being used to "bind" organizational parts together, boundaries had been placed around the organizational functions of production and finance. Such a situation was not, however, altogether "dysfunctional" as such boundaries acted so as to "seal" the problems of one area from another – specifically, pessimistic financial information did not filter through to disrupt productive activities. Thus, "Fluctuations in markets or financing do not get reflected in the assessments of colliery viability" (p. 17). This scenario had another implication for boundaries: the productive boundaries of the NCB were emphasized to the neglect of the financial ones, "... Area and Colliery levels have ... been regarded as 'Production Centres' ...by concentrating on production (that is maximising output, manpower and machinery utilisation) the financial results ... will automatically meet requirements" (p. 9).

However, such a situation was engendering a conflict between the management of internal tensions and the maintenance of the external organizational/societal boundary. During the time of the study the socio-economic environment was becoming less benign (p. 15). Consequently there was increasing pressure on the NCB to demonstrate rationality and legitimacy to external regulators (such as the government and the media) by being seen to manage financial uncertainties. However, the boundary strategy of sealing off production from finance, allied with a culture which defined organizational purposes in productive rather than financial terms, was exacerbating the difficulties of effective external boundary maintenance. Internal boundaries were being managed so as to shield the technical core but uncertainties were building up on the organizational/societal boundary. Subsequently "thresholds" at the NCB were to break down resulting in the organization being overwhelmed by the cumulative pressures of decreased demand, economic recession, governmental distrust of the nationalized industries and a market-oriented policy for fuel.

As the above study demonstrates, processes of change are often enacted through the challenging of dominant boundary definitions and through shifting patterns of boundary activity. A research focus on the role of agency in reconstituting boundaries reveals that a change in the "gatekeepers" (or those who manage the external boundaries of the organization) always brings potential changes in the power structures and systems of meaning within the organization. Dent (1991), in a case study of change at a state railway, shows how when "gatekeeper" roles are assumed by profit-oriented "Business Managers" (thus excluding the "general managers" who were preoccupied with engineering and logistics), the definition of the organization through productive

boundaries is challenged and the management of external uncertainty takes place through accounting, rather than productive, information.

Thus "to organize" involves the management of internal and external uncertainties. When change is seen as engendered by the tensions between internal and external boundary management a research agenda on organizational transitions is revealed.

Some Consequences of a Neglect of Boundary Maintenance Ideas for Organizational/Social Theories

As boundaries mark the differentiation of the organization from society a study of boundary maintenance ideas should clarify the relationship between organizational and social theories and, hence, assist in the analysis of situated accounting practices.

A neglect of boundary maintenance theory has had the consequence of creating a rift both historically (Reed, 1985, p. 61) and analytically between organizational theory and social theory. Historically, some theorists have seen such a division as beneficial. Albrow (1968), for example, prescribed a clear distinction between the "sociology of organizations" as an intellectual domain where social theory could address the sociopolitical agenda within organizations and "organizational theory" as a technocratic concern "... pervaded by the managerial interests of improved organizational efficiency and effectiveness" (Reed, 1985, p. 108). Donaldson (1985) defended the intellectual terrain of organizational theory against an oncoming tide of social theory – denying that organizational theory could ever be engulfed by social theory. A separation of the two domains was recognized, but not prescribed, in Covalleski and Aiken's (1986) analysis of the development of organizational theory as an "applied" analysis, in contrast to which social theory is "detached" from any managerial prescriptive bias. But such a schism has had a number of consequences. First, the assumption that organizations are intrinsically ordered places, rather than produced as such, neglects the extent to which rational-instrumental behaviour is subject to social or interactional forces (Boland and Pondy, 1983; Cooper, 1990; Gouldner, 1959). A focus on individual behaviour results in organizational theory only incorporating such psychological concepts as functional fixation and agency theory as it recognizes the problems created by bounded rationality (Simon, 1947) and opportunism (Williamson, 1970). A neglect of social theory also produces an organizational theory which is dominated by "... a grey collection of managerialist typologies" (Parker, 1992, p. 1) as power, culture and symbolism are conceptually excluded from the organizational arena. Second, if the organization is seen as inherently unitary rather than continuously reproduced as such, then the organization and its environment become disconnected and tendencies to see the organization as a self-sustaining entity are preserved. Such a disconnection not only ignores boundary activity, it denies any possibility of organizations joining "... with

their surrounding cultures for purposes of mutual empowerment ..." (Gergen, 1992). Third, the system metaphor, central to managerial organizational theory, implies a structural-functionalist methodology and therefore excludes any analysis of social relations within organizations (Silverman, 1970).

This separation of the domains of social and organizational theory has had a powerful impact on the analysis of accounting practices. Sociologists, while writing extensively on power and authority, have largely neglected the concrete embodiment of these concepts in accounting systems of co-ordination and control (Johnston, 1986). Why this has happened is uncertain but Zald (1986) suggests that it results from the sociologists' view of accounting as "fixed" and "... part of a technical cultural process which need not be analysed" (p. 328). That sociologists think in this way is not unconnected from the "capture" of the concepts of control and co-ordination by the managerial concerns of organizational theorists. Consequently, sociologists have not analysed "the fundamental tendency of all bureaucratic thought ... *in turning* ... all problems of politics into problems of administration" (Mannheim, 1936, quoted in Cooper, 1989; italics indicate author's insert). Boundary maintenance theory aids the understanding of how the disconnection between social and organization theory has occurred and also points to the ways in which social and organizational theories could be reconnected through the nesting of the manifest processes of co-ordination and control in the rather more abstract social theorizing around power and authority.

Conclusions and Implications for Research

Traditional organizational theory assumes that:

By gaining knowledge, we acquire power over organizations; we can design them and be experts on them ... The aim of this expertise follows the grand narrative of progress which is manifested within organizations as a concern for "efficiency", "minimization of conflict" and "profitability" (Parker, 1992, p. 5).

From this perspective accounting comes in as a technical artefact, in a reflective rather than a constitutive role, and carrying the assumption that it can produce prescriptions for improvements in internal organizational design. In contrast this article has sought to locate accounting within "... the production of the organization rather than the organization of production" (Cooper and Burrell, 1988, p. 106). Hence, it has identified the ways in which accounting is implicated in boundary maintenance. Implicit in this approach is the notion of agency. To be an agent "... is to have the capability of 'making a difference'" (Giddens, 1982, p. 212). This article sees accounting as a resource, drawn on by agents, not only to "make a difference" within organizations but to "create a difference" between the organization and society. Such a difference is achieved by maintaining boundaries as "thresholds" and managing boundaries as "binding structures". This involves seeing "organization" "... as a process verb that needs disorganization in order to exist" (Parker, 1992, p. 6). The process of

organizing happens at organizational boundaries, as agents or "gatekeepers" manage the exigencies of inclusion and exclusion in the production and reproduction of organizational realities.

Therefore "to organize" involves a negotiated understanding of organizational realities and an interpretation of these in relation to environmental realities. Organizations must, therefore, "... achieve a form of self-referential closure in relation to their environments, enacting their environments as projections of their own identity or self image" (Morgan, 1986, p. 240). In this process of enactment, the internal information collecting and processing systems of the organization have profound effects on what signals are received from the environment and on how these signals are received (Scott, 1981b, p. 173). Thus organizational scan, search and information processing facilities enact the environment as a significant representational context by transforming it from being merely "... 'everything else' – that is everything that is not system" (Scott, 1981b, p. 165). Thus, accounting information is implicated in the construction of environmental realities in order to aid organizational understanding of both what to attend to and how to interpret it.

This role of accounting is clearly brought out in the Berry *et al.* (1985) case study on organizational change. Where, as in the Berry *et al.* study, accounting information is disconnected from productive activities, internal boundaries protected the technical core of the organization, but the concomitant neglect of the external societal boundary resulted in the eventual breakdown of the organizational/environmental threshold. Such a study suggests that boundary management ideas can usefully be applied both in the understanding of how organizations achieve a negotiated equilibrium and how such stability can be undermined by boundary tensions and shifting boundary emphases. Thus, boundary management ideas have both theoretical implications for the understanding of the organizational/social context of accounting (as the preceding section outlines) and empirical significance for rich accounting case studies (of particular interest may be the catalyst role of boundary tensions in engendering organizational transitions).

The paradox of the organization as an embedded, yet differentiated, form of social life can, therefore, be viewed as reflecting the interdependencies between the organization and its environment. The organization is embedded in society in its use of environmental information for self-understanding but, at the same time, the organization is differentiated from society by managing boundaries to maintain its own internal identity. Such an approach challenges a traditional static and structure-biased organizational theory and presents an understanding of organization as process. In consequence the role of accounting in the processes which achieve organization is revealed.

Notes

1. Although Foucault is usually seen as making a contribution to the post-modern debate his work is difficult to categorize and he himself rejected the post-modern label. He is referred

to here to highlight one facet of his work, i.e. that facet which stresses the pervasive, ubiquitous nature of discipline within organizations. In contrast to this view of the self-sustaining nature of organizational power this article develops ideas of organizational processes as achieved by boundary maintenance.

2. Heydebrand (1989) provides an analysis of how intraorganizational forms are related to certain structural dimensions of labour.
3. Clegg's view may be taken to imply that agency is not always accomplished through individuals. This article, however, adopts a formulation which sees agents necessarily as people but, such a position does not imply that agency always equates with the intentions of purposeful individuals. The "forms of calculation" (including accounting) through which agency is expressed are institutionally constructed. Such "forms of calculation" can be compared with Giddens's notion of the "resources" or structured properties of social systems which are drawn on by agents in the course of their interaction.
4. These linkages (i.e. between "thresholds" and financial accounting and between management accounting and "binding structures") are not always complete. Clearly budgeting, for example, can serve to maintain "thresholds" by convincing external regulators that efficient planning systems are in place (the use of management accounting to supplement reliance on financial accounting is documented in the history of the NHS). Nevertheless it is argued that, although blurred, these distinctions are useful.
5. Intellectual technologies encompass both information processing and decision making through specialized consultancy services.

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Purchasing power and polarized professionalism in British medicine

Purchasing
power and
professionalism

31

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Introduction

The inception of fundholding – the opportunity to hold a budget at practice level – for general practitioners (GPs) has constituted a critical, formative moment for intra-professional relations in British medicine. Fundholding conferred purchasing power on GPs; this paper argues that they are using this financial leverage to enhance their influence within the British National Health Service (NHS). The mechanisms of fundholding have enabled GPs to accommodate their “latent desire” (Glennester *et al.*, 1993, p. 74) to shift the balance of power between themselves and the hospital consultants. This desire had remained latent as any overt intraprofessional challenge would have threatened public perceptions of all medical experts as exemplars of rationality, impartiality and civility (Dezalay, 1995; Ezzamel and Willmott, 1993). Societies rationalize socially significant but unclear (or uncertain) domains, such as medicine, by professionalizing them and handing over decisions to licensed practitioners (Meyer, 1994, p. 222). Any conflicts signalling irrationality will, therefore, undermine claims to professionalism. Fundholding presented GPs with an opportunity to engage in “turf battles” (Dezalay, 1995) and renegotiate their relationships with the consultants without risking damaging the overall reputation of the medical profession as fundholding was a political initiative rather than a professional challenge. While successive governments have set overall funding levels for the NHS, they (prior to the health service reforms) accepted the autonomy of the medical profession to allocate resources within the NHS. This concordat ensured that awkward decisions about “who gets what” remained within the realm of expert professional judgement and did not become politicized – and, hence, seen as the responsibility of government (Klein, 1995, p. 96). The opportunity presented to GPs through fundholding added a reverse direction to this prestanding accommodation as covert

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professional medical renegotiations were conducted through an overtly politicized medium.

The reorganization of health care by the State through the inception of the NHS in 1948 had intensified the divisions which already existed between GPs and consultants by removing the financial ties which linked them. From 1948 onwards consultants were paid largely by the state and GPs, as a source of private work, through referring patients to the hospitals, declined in importance; concomitantly, after 1948, GPs' capitation fees were paid by the state regardless of the number of patients they referred to consultants (Honigsbaum, 1979, pp. 302, 308). The severing of these monetary bonds widened the professional divide within British medicine. "The plain fact is ... that a hostility exists between two sections of the profession. The conception of the colleague...is dying, if it is not already dead...This is a tragedy for the profession; it is a tragedy for the public; it is a tragedy for the National Health Service..." (*Creditor*, 1971 quoted in Honigsbaum, 1979, p. 299).

Fundholding re-opened communications between GPs and consultants as it re-established the financial ties between them. This paper delineates three domains within which GPs are working with budgets to renegotiate medical agendas through exerting financial leverage: first, the use of contracts to specify (to the advantage of GPs) processes of case management at the interface with the hospitals; second, the use of contracts to press for particular quality standards in the clinical practice of hospital consultants; and, third, the use of the increased financial flexibility conferred by the budget to "take back" certain surgical procedures from secondary care to primary care. These are all domains where GPs perceive that consultants have exercised control without accountability to GPs or to patients. As one GP in the empirical study (referred to in detail below) remarked,

They [the consultants] thought that when they were given a consultants' job they were deified on the same day.

The paper begins by examining the dominance structures which exist between consultants and GPs, the research design is then explained – followed by the accounts of the GPs interviewed. These accounts explore four areas where fundholding impacts on GP – consultant relations: the hospital interface; the expansion of primary care; GPs' managerialism; and, finally, the interwoven agendas of money and medicine. The accounts capture a very unique moment in the development of fundholding, being focused on the initial stage of the scheme. They are based on evidence from GPs who have been particularly instrumental in establishing fundholding and in articulating its aims and objectives (see the further discussion below on research design). This approach does not deny that many GPs are opposed to fundholding, even though they may acknowledge that the scheme has elicited a greater responsiveness from the Trust hospitals (for a discussion of some of the issues which divide fundholding and non-fundholding GPs see Llewellyn and Grant, 1996). The principal aims of this paper are, first, to present evidence on why GPs who are

enthusiasts for the scheme embraced it so readily and, second, to discuss (again through reference to the arguments of GPs themselves) their unfolding projects as fundholding develops. The paper examines GPs' use of budget holding as a control device to achieve changes in the process of the provision of health care – particularly in terms of GPs attempting to redress the balance of control of health care provision between themselves and the consultants.

The paper does not discuss the government's ongoing commitment to enhancing the control of the medical profession as a whole (for accounts of this process, see for example, Lapsley, 1994 and Laughlin *et al.*, 1992). In its focus on the three-way contractual and managerial relationships between GPs, consultants and managers (in the Trust hospitals and the health boards) the paper also sidesteps the issue of the increased managerial control which is now exercised over GPs by the Family Health Service Authorities[1] (for a detailed discussion of this enhanced accountability see Laughlin *et al.*, 1994). Following the accounts from GPs the paper concludes with comments on the present and possible future direction of fundholding within the British NHS. Table I gives some explanatory detail on the relative positions of GPs and consultants in British medicine and on the reformed UK health service.

Intra-professional power relations in medicine

This paper uses the work of Abbott (1988, pp.118 ff) to theorize internal differentiation and relations of dominance within the medical profession. Abbott uses the central concept of jurisdiction to understand professional work. Jurisdiction implies control of knowledge and its application which, in turn, involves the exclusion or domination of outsiders who attack that control;

GPs	General practitioners (GPs) are doctors who have undertaken the same initial medical training as their colleagues in the hospitals but who, on registration, transfer out of the hospitals into the community to practise as generalists rather than specialists.
Consultants	Consultants are medical specialists who work within hospitals. They may be either physicians or surgeons and they hold the highest appointment within their particular branch of medicine or surgery (termed a specialism). They do not offer holistic care of the whole body (apart from those specializing in paediatrics or geriatrics) but diagnosis and treat a part of the body (e.g. cardiologist is concerned with the heart and its diseases).
Trust hospitals	Trusts are semi-autonomous self-governing hospitals. They are able to set their own levels of remuneration for their workforce but are subject to external financing limits which limit total borrowing for capital projects. They are also required to earn a 6 per cent return on assets in use. They are directly accountable to the Secretary of State for Health.
Health Boards	Health Boards (District Health Authorities in England) are bureaucratic bodies which had previously (prior to the purchaser/provider split) run the hospitals; now the role of Health Board managers lies in purchasing (for non-fundholders and for those services not covered by fundholders' budgets e.g. emergency treatment) and in planning.

Table I.
The main protagonists
in the fundholding
scheme

hence, professional activity always involves competition. Within this analysis professional development is not essentially a process of professionalization – involving association, licensure and the formation of ethical codes – but is a history of jurisdictional disputes (pp. 2ff). Such disputes are about who controls what, when and how. Sequences of jurisdictional control are played out as jurisdictional boundaries come under attack. Abbott writes on both interprofessional and intraprofessional disputes; it is the latter which is considered in this paper – in the context of the GPs' struggle for greater control over medical practice through a challenge to the jurisdictional dominance of the consultants. Along with Abbott, the paper uses principally the work of Honigsbaum (1979, pp. 2ff) to understand the historical dimensions of intra-professional medical conflict and it is the historical dimension which is considered here first.

Historically, issues of philosophy, training and social attitudes created divisions in British medicine and provided a rich field for territorial disputes (Dingwall, 1995, p. 227). At the beginning of the nineteenth century there were three distinct categories of medical personnel – physicians, surgeons and apothecaries – and it was from the latter that the modern GP role emerged. These origins stigmatized the early GPs – as apothecaries had combined their dispensing duties with the sale of groceries and, hence, they carried negative “tradesmen” associations (Honigsbaum, 1979, p. 2). Trading introduced a financial rationality into the developing professional milieu of medicine and hence the early GPs were not as successful as the physicians and surgeons at distancing themselves from the logic of the market (Dezalay, 1995). As the nineteenth century progressed doctors were assisted by the appearance of microscopes and stethoscopes for clinical examination in the process of excluding patients and amateurs from participation in medical practice (Dingwall, 1995, p. 239). In 1858 doctors, still struggling with one another over territory and with the government over their social standing, succeeded in getting the Medical Act passed (Reader, 1966, p. 66). This act created the General Medical Council, a body with two main duties, to ensure that unfit practitioners do not get on to the medical register and to expel unworthy members from the profession (Carr-Saunders and Wilson, 1933). The Council, imbued with the prestige and authority of the state, formalized the principles of, first, proper professional education (tested by examination and awarded by licence), second, professional self-discipline (through registration and striking off) and, third, statutory recognition of the rights of the qualified practitioner (with sanctions against the unregistered); these principles instituted that most prized attribute of professionalism “...the closed shop with an Act of Parliament to lock the door.” (Reader, 1966, p. 68).

Medical science advanced throughout the nineteenth century and, as the “centre of gravity” for the generation of medical knowledge moved from the bedside to the hospital (Seale and Pattison, 1994), hospitals spread rapidly. Access to these hospitals provided physicians and surgeons with the opportunity to specialize. By the end of the nineteenth century the development

of anaesthesia and antiseptic techniques had made surgery respectable; previously its status had been threatened by the "messy, painful and hazardous" nature of surgical practice (Honigsbaum, 1979, p. 3). At this time GPs were performing a variety of surgical procedures and the surgeons had retaliated by usurping aftercare from the GPs (Honigsbaum, 1979, p. 14). Thus prior to state intervention, access to the hospitals in order to practise specialized medicine was an issue which created tensions between GPs and consultants and a medical occupational hierarchy had been established based on class origins and techniques. However, these tensions were suppressed through the privatized nature of medicine. An uneasy concord was maintained as consultants were dependent on GPs for income through the referral system. All referrals to the hospitals came through the GPs, but once patients were hospitalized the consultants took charge. Although this referral system regulated competition within the medical profession, it was identical to those systems which controlled forms of inter-professional rivalry, being "... essentially a demarcation agreement between two crafts, of exactly the same kind that developed between different crafts in shipbuilding and other British industries." (Klein, 1995, p. 79).

Extension of coverage, (with its promise of a better life for all), rather than cost containment, was the focus of the health care debate in the aftermath of the First World War as the government took steps to allay a public outcry at the loss of life involved (Honigsbaum, 1979, p. 53). This directed attention on the hospitals as the centres for technological progress in health care and, hence, as the determinants of the future health of the nation. State perceptions on the significance of the role of GPs declined as they did not contribute towards the advancement of medical knowledge. But in the 1980s, as health care discourses reverted to cost containment the importance of the general practitioner as a controller of the consumption of health care resources has again been highlighted (Klein, 1995, p. 164). Nevertheless the potential role of fundholding within the wider reforms of the NHS was understated. GP fundholding constituted a mere "sideshow" (Glennester *et al.*, 1994, p. 74) to the creation of the Trust hospitals with their semi-autonomous status (see *Working for Patients* (SSH, 1989) for further information on the UK health reforms).

That the impact of fundholding was unexpected is attributable to the public "invisibility" of the intra-professional conflict between GPs and consultants (Abbott, 1988, p. 121); but this conflict was to galvanize fundholding processes. Such an analysis explains why GPs have taken voluntarily to fundholding (fundholding now covers one third of the UK population and, in some places, coverage is over 70 per cent (NHS Executive, 1995)) whereas the tale of persuading hospital clinicians to hold budgets has been tortuous (Lapsley, 1995). As the study described below demonstrates, GPs anticipated power gains through holding budgets; hospital clinicians did not. Hence, this paper delineates the "differential appeal" (Humphrey *et al.*, 1993, p. 18) of fundholding for consultants and GPs. In short, fundholding GPs perceived themselves to be

in control of the reforms but the consultants saw them as threatening. One GP from the empirical study (described in detail below) expressed this as follows:

They [the consultants] see the NHS being GP-led rather than consultant-led – that's the source of the threat they feel.

Internal differentials give rise to the problem of power and, hence, create intra-professional tensions. Abbott defines four areas of internal differentiation: intra-professional status; client differentiation; organization of work; and career pattern. Along all these dimensions GPs and consultants are polarized – with GPs occupying lower status roles and performing lower status tasks. Yet, prior to fundholding as a political initiative, GPs had failed to launch any professional challenge to the consultants' dominance over medical terrain. That they had not done so may be attributed, first, to their reluctance to expose intra-professional tensions to the public gaze and, second, to the lack of a mechanism which would facilitate such a challenge. Fundholding was a politicized initiative instigated by the state, it constituted a disturbance to the balance of power between the GPs and the consultants but it was a disrupting mechanism which was introduced into (rather than lay within) the medical terrain. Abbott has been criticised for neglecting the significance of external challenges (or mechanisms) which give rise to professional renegotiation of territory (Dezalay, 1995; Sikka and Willmott, 1995). In the case of intra-professional (as opposed to inter-professional) disputes "externality" is particularly important, as an external mechanism can be converted into an internal challenge without damaging the credibility of the profession as a whole. Fundholding as a state-sponsored financial mechanism allowed a covert intra-professional challenge to be launched by those GPs who sought to raise their status *vis-à-vis* their hospital colleagues.

Professional regression

Intraprofessional status differentiation allows for "professional regression" where, in the medical sphere, consultants see only patients who are referred by other professionals (in the British context GPs). This referral system fosters an environment where GPs must mediate in the patient world by seeing patients as people. People often have a complexity of medical, social and financial need. Front-line GPs, in their referral role, strip patients of their extraneous non-medical needs (Abbott, 1988, p. 41), enabling the consultant to review a "preprofessionalized" case – presenting with only medical signs and symptoms. Moreover consultants work in specialisms dealing solely with parts of the body – only in the case of the very young (paediatrics) or the old (geriatrics) will hospital doctors treat the whole person. This task differentiation allows consultants to regress to a "higher ground". "In the varied topography of professional practice, there is a high, hard ground where practitioners can make effective use of research-based theory and technique, and there is a swampy lowland where situations are confusing 'messes' incapable of technical solution." (Schon, 1988, p. 67). This problem is solved in the British medical

profession by locating GPs in the swamp. In this swampy zone GPs must work through experience, often employing trial and error, as they cope with patients as "confusing messes" presenting with signs and symptoms of organic, psychological or social origin (Armstrong, 1980, p. 74). On the hard, high ground consultants can satisfy their hunger for technical rigour and buttress the public view of clinical practice as one of solid clinical competence (Schon, 1988, p. 68). Consequent on consultants' higher involvement with the medical knowledge base and the GPs' "dirty work" with non-medical client problems, consultant *vis-à-vis* GP status is much enhanced. Hospital surgeons and physicians are "professionals' professionals" (Abbott, 1988, p. 118) who are enabled by the GP referral system to regress from front-line tasks and who, consequently, enjoy high peer esteem and high incomes.

Client differentiation

Client differentiation occurs when superordinate-subordinate sectors of a profession serve different client groups. The higher status professional deals with the higher status client and vice-versa; this client differentiation reinforces the task differentiation (referred to above) as a professional "...who serves high status clients receives some reflected glory, just as one who serves charity cases receives some reflected opprobrium." (Abbott, 1988, p. 122). Currently in the medical profession only hospital consultants see private patients – receiving the payments from clients which are the publicly visible signs of the value of their specialist expertise; since the inception of the NHS the public have not perceived any benefits in paying GPs for private treatment. Aside from client status, consultants and GPs also favour different types of client. GP fundholding has been criticized on the grounds that it builds in an incentive to "cream skim" (i.e. to exclude from the practice list those patients whose medical conditions necessitate costly treatments) (Glennester *et al.*, 1993). In contrast, consultants, as medical technocrats (Klein, 1995, pp. 25ff), will prefer patients with unusual, complex or serious and, hence, costly conditions. These patients will require highly technical medical interventions and, hence, such patients will justify the deployment of expensive technology. Clients with complex medical conditions will frequently be referred between specialists; they will, therefore, be agents for cross-fertilization of ideas between specialties. Consultants can also seek to advance their careers by publishing papers which interrogate unusual afflictions through the pursuit of the "...purely professional activity of research." (Abbott, 1988, p. 123). Clients with esoteric conditions are more interesting as they fully engage the specialist knowledge base of the professional; GPs must always refer such patients on to specialist treatment centres, they are not "fit" to serve them. GPs work with the trivial, the superficial and the most boringly familiar of medical cases; in consequence, the GPs' public image is somewhat staid if not dull. Patients with serious, unusual or complex conditions will, *ceteris paribus*, be more costly. Therefore fundholding GPs and consultants are also distinguished by "client cost incentive". Consultant "client cost incentive" militated against non-emergency

cases, minor elective surgery and out-patients; these were precisely the categories which were targeted within the fundholding scheme and, hence, included in GPs' budgets.

Differentiation of workplace

Linked to professional regression is the differentiation of workplace for the consultant and the GP. High status consultants work in the highly regarded "teaching" hospitals which are centres for medical research and the advancement of medical knowledge. Within these teaching hospitals consultants have been able to develop the "firms" which further concretize and advance their power. Consultants need subordinates to undertake the more routine "scut" work such as giving injections, clearing sores, taking histories and even conducting minor surgery (Abbott, 1988, p. 126). GPs are suitable candidates for this delegated work. In the "cottage" hospitals which flourished before the Second World War[2], GPs did perform these tasks (Honigsbaum, 1979, pp. 10-11). However, there was consultant anxiety over the impact of non-specialist GPs on the quality of clinical practice – one leading surgeon in 1946 claimed that "more people are killed than cured in cottage hospitals" – and the GP came to be regarded as a menace in the hospital world (Honigsbaum, 1979, p. 306). During the 1950s cottage hospitals began to close down. Both to deny GPs access to hospitals and to allow for the accommodation of private practice the "firm" concept was developed from the inception of the NHS. Consultants began to supervise as many as six "assistants" – a senior registrar, two registrars, a senior house officer and two house officers (Honigsbaum, 1979, p. 294). So a division of labour evolved within the health service where routine, "degraded" work was given over to junior doctors and GPs were pushed back into the community.

Differentiation in career progression

Differentiation of workplace dictates sharply divided career paths for the "hospital" doctor and the GP. Although both share the protection that professionalism provides against the instabilities of capitalist employment (Abbott, 1988, p. 132), GPs have a stable, comfortable, if essentially static, career pattern. In contrast hospital doctors, owing to the pyramidal structure of the "firm", face a riskier progression through a career hierarchy and, owing to the relative infrequency of vacant consultant posts, may be forced to seek employment in a lesser status institution or leave Britain for abroad. Essentially GPs take on a lower status front-line peripheral role away from the main centres of medical power in exchange for some freedom from the rigidity and supervision inherent in the "firms". In doing so, however, they sacrifice the possibility of career development and risk their clinical practice degenerating into repetitive routine.

Collegial status is also denied by the "gatekeeper" role which GPs perform on patient access to the specialist expertise obtained in the hospitals (Bevan, 1989). In the USA and other European countries, patients may go straight to a

specialist opinion and as a result health care costs are higher[3] (Klein, 1995, p.163). This "gatekeeper" role acts so as to filter out those non-serious conditions which do not require specialist attention. "Gatekeepers" also limit access to those expensive treatments which are rationed. For example, older patients are not referred by GPs for dialysis as GPs are aware that consultants ration this treatment by age (Schwartz and Aaron, 1988). This convention spares the consultants from having to deny treatment and avoids a painful rejection for the patient. The front-line "gatekeeper" role which GPs provide simultaneously serves the state by limiting costs[4] and facilitates the decisions which consultants make on health care rationing.

Internal differentiation within a profession generates intra-professional tensions which can escalate into hostility if not publicly visible conflict (Abbott, 1988, p. 117). Consequently, such tensions may be a source of professional development. The argument of this paper is that fundholding provided an appropriate medium for renegotiations between medical professionals through safely channelling intra-professional tensions through an accounting-based initiative.

The research design

The paper draws on data from an empirical study conducted in the three regions which have been most closely associated with the development of fundholding in Scotland (Grampian, Lothian and Tayside). The methodology which underlines this study is to trace the early dynamics of fundholding through, first, identifying the key players who are driving the processes of fundholding and, second, analysing the critical structures which define and constrain these processes of agency. This approach also differentiates between key players by focusing on how they seek to impact on these critical structural conditions. This methodology combines Giddens' (1984) analysis of structure and agency with Sayer's (1992) understanding of structures with "emergent powers".

All but one of the key players interviewed during the research were lead fundholding GPs within their practices. Two lead fundholders were also chairmen of their regional fundholding associations and, therefore, headed up the regional negotiations on contracts with hospital Trusts. All were to some degree involved with increasing the range of medical services within their practices but one GP had been particularly prominent in this respect. This practitioner ran what was generally recognized to be the most innovative surgery within Scotland; this practice had its own ambulance, owned a number of diagnostic facilities and offered on-site minor surgical procedures. It equated to the old "cottage" hospital and publicized its activities through its resident part-time journalist. The one interviewee who was not a lead fundholder was a GP surgeon and performed a one-day weekly surgical list. This surgeon competed with the local hospitals for minor surgical procedures not requiring general anaesthesia. In the sections which follow, these "key players" are referred to as TD1, LD2, GD3 and so on where T, L or G indicates

the Scottish region (Tayside, Lothian and Grampian) within which the practice was situated and D1, 2 or 3 relates to the chronological order in which the doctors were interviewed. Seven fundholding GPs in all were interviewed, two in each of Tayside and Lothian and three in Grampian – where the third interviewee was the aforementioned GP surgeon. Practice or fund managers were present at these interviews but this paper does not make reference to their views as the paper concentrates on the impact of fundholding on the relationship between the GPs and the consultants and the GPs dominated the discussion on these issues. As a part of the study, three non-fundholding GPs were also interviewed but this paper makes reference to the comments of only two of these – where the comments were germane to the territorial battles between GPs and consultants. These non-fundholders are identified as NF1 and NF2.

The interviews conducted with these key players sought to identify agents' reflexive monitoring and rationalization of their action; these accounts of agency were then interrogated to discern the overall plans, programmes or projects of the agents concerned and how these were constitutive of the development of fundholding. This approach follows Giddens' distinction between reasons and motives where reasons refer to the grounds of action and motives refer to the wants which prompt them. Motives only usually having a direct purchase on action where circumstances break with routine (Giddens, 1984, p. 6). The inception of fundholding fractured the routines of general practice and hence supplied opportunities for agents to realize projects which had previously been suppressed. One GP expressed this as follows:

Both the Chairman of the Health Board and the BMA were opposed at that time [at the beginning of 1991], there was very little on paper, we asked naïvely "Is there a manual?" but soon we realized that we had the opportunity to write the manual ... We shared information among ourselves and any GP who was interested. (GD1)

Fundholding enhances the abilities of GPs to "make a difference" (Giddens, 1984, p. 14) to the course of events through the exercise of purchasing power. Power, in this sense, equates to transformative capacity (Giddens, 1984, p. 15). However, although fundholding has released the transformative capacities of GPs as agents, fundholding carries certain structural properties which define and constrain GPs' processes of agency. Structural constraints dictate how the initial budget is set, the scope of services included within the budget and the ways in which any "savings" can be used. Potential fundholding practices are also screened for size and managerial capabilities. Historic expenditure patterns[5] continue to form the basis of the budgets set but it is the government's intent to continue to move towards weighted capitation (i.e. where budgets are set on the basis of number of patients weighted by indicators of need such as age and sex and, possibly, social deprivation, see, for example, Sheldon *et al.*, 1994 for a discussion of possible capitation formulae). In terms of scope, initially budgets covered only hospital out-patient services, elective in patient and day cases, diagnostic tests, drugs (prescribed and dispensed), practice staff costs and certain accommodation costs. Latterly, however, this

“standard” fundholding option has been supplemented by community fundholding (which excludes acute hospital services) and total fundholding (which covers all services). Fundholding now comes in these three variants in terms of scope. Expenditures may be shifted between budget heads and overall underspends, once audited, may be used in improving practices and offering better services to patients (as judged by the GPs concerned). Initially fundholding was open only to GPs with a minimum list size of 11,000; practices also had to demonstrate that they were technically (in terms of information technology) and managerially capable of handling the changes involved. The minimum list size has been progressively reduced; it now stands at 4,000. For further details on the structure of fundholding see the series of government directives from NHS Review Paper 3, (SSH, 1990) to NHS Management Executive (1995). The paper now turns to examine the accounts of GPs, first, on why they chose to embark on fundholding and, second, on the projects they are now trying to realize.

GP fundholders and intra-professional power relations

The following accounts from fundholding GPs on their reasons for going fundholding and on their developing projects cover four areas: first, communications with the Trust hospitals; second, the expansion of primary care; third, how contracting between GPs and consultants has marginalized managers in the Trust hospitals and the Health Boards; and, fourth, an exploration of the diversity in terms of what GPs are attempting to realize through fundholding. As stated in the earlier section on research design the GPs quoted below are all enthusiasts and “early-takers” – key players in the development of fundholding in Scotland. As one stated:

Some fundholders end up just exchanging paper with providers; we wanted to change things drastically. (TD1).

Hence these accounts cannot evaluate the general impact to date of fundholding throughout Scotland. As Day and Klein (1991) argue, fundholding has long-term implications which are difficult to predict, being dependent on the future uptake of the scheme and it will be a long time before there can be any evaluation of the scheme in terms of its impact on patient care. Moreover, as the above quote indicates, all fundholders do not pursue change through the scheme with the same degree of commitment; the Audit Commission (1996) reported that only around 10 per cent of fundholders were responsible for the significant impact of the initiative. This research sought to access the views of this crucial 10 per cent.

What the accounts do show are the “conditions of possibility” (Latour, 1987) for fundholding or its emergent powers (Sayer, 1992, p. 118). These conditions of possibility or emergent powers may or may not be fully realized being dependent on how future processes of agency track through all the institutions concerned.

GPs use fundholding to regain ground lost to the consultants at the hospital interface

Fundholding constitutes a potential disturbance to the balance of power between the GPs and the consultants – as doctors who have jurisdiction over money also have some jurisdiction over medicine. The following comments from fundholding GPs illustrate this perception. First, from the perspective of the historic advantages of the consultants, who, through professional regression, control the medical knowledge base (Abbott, 1988, p. 118) and, hence, have a privileged access to resources:

There's a lot of historic baggage, the medical schools always got all the resources – you know how it is, I don't need to tell you – it's the people who bring the money in, they get all the resources...The Scottish health service is dominated by the medical schools, we wanted to break their monopolies. (TD1)

The acute sector always dictated priorities – all the high-tech things – any money left over went to GPs. (NF1)

and, second, on the emerging power of the GPs through the use of budgetary control,

If we've got the money that's what the Trusts will respond to, if we withhold the money they'll have to respond. (GD1)

If you've got control over finances you've got more clout. (TD2)

If there's no funding behind it, very little happens – you're shouting from the trees, you're toothless. (LD2)

One GP recalled his frustrating experiences of “shouting from the trees” when he sat on joint consultative committees with consultants in his pre-fundholding days,

We [the GPs] always brought up the same issues – quality, waiting times [for patients], delayed or no reports back – there were always the same excuses, the same processes produced no change, it [the hospital] remained a great black hole. (GD1)

The local consultants' response to GPs' newly acquired resources in the early days of fundholding was confrontational:

You know what they [the consultants] said? They said, “You've got our money – give it back”...that's what they said at first – they actually said that. (TD1)

The contracting process makes consultants accountable and accountability (even to other doctors) has been an alien concept to hospital clinicians (Hunter, 1992, p. 561). Documented forms of surveillance have been unheard of for consultants who, in practice, have been accountable to no one, except the General Medical Council and then only for the most exceptional cases of abuse or error (Walby and Greenwell, 1994a). Consultants have been free to make a whole range of decisions over the tasks they perform: how many patients to admit and which diagnostic and therapeutic procedures to carry out; how to schedule out-patient appointments; how to utilize their allocation of beds (in terms of turnover); how to manage junior doctors; and how to pursue clinical interests (Schulz and Harrison, 1990, p. 346). Although the government has

attempted to introduce greater external accountability for hospital clinicians, particularly through medical audit, research done on the implementation of audit concludes that it is functioning so far as a tool of medical self-management, particularly *vis-à-vis* the education of more junior colleagues by consultants, and medical accountability to external agencies has not been enhanced (Kerrison *et al.*, 1993). Similarly Laughlin *et al.* (1992, p.137) note "...this [medical audit] does seem to be an area where the initiative has been taken back into the professions' hands."

In England Glennester *et al.* (1993) found that contracting was slow to get under way as providers did not take GP fundholding seriously; most participating practices had to make repeated attempts merely to locate someone within the hospitals who was prepared to talk to them; the idea that practices may want to negotiate improvements in services was treated "with incredulity" (p. 92). Not surprisingly consultants in Scotland also at first resisted contractual forms of accountability:

We [the GPs] thought we would be kind and gentle at the beginning, we wanted to get into a dialogue with them [the consultants] but we found out that we needed to move a few patients to have an impact – but it only needs to be at the margins... They're [the consultants] so reactive to any change, there's this dreadful built-in conservatism... Relationships [with the consultants] aren't always very good, in fact I'm sure my name's mud. The younger ones see the need to engage in a dialogue but the older ones think it's appalling that GPs are even studying these questions [standards of service]. (GD1)

All GPs in this study used their purchasing power to influence processes of care management at the hospital interface – improving communications from the hospital to the GP surgery, cutting back on waiting times and ensuring that patients saw a consultant rather than a junior member of the "firm" whenever GPs felt that their condition warranted a consultant opinion. The following comments illustrate the impact of GPs' purchasing power on these care management processes:

A number of things have improved – discharge letters – sometimes we just didn't get them or it would take six weeks, now it's supposed to be seven days and they manage ten days. Drugs on discharge is another – they [the consultants] used to just throw them [the patients] out and if we were closed – if it was a holiday or a weekend, then they couldn't get their drugs, now they give them seven days' worth. (TD2)

The most noticeable improvements are communication between hospital doctors and GPs – there are regular meetings now – they keep us posted about new services, new consultants, tell us about new ideas – in the past they'd do things like stop ECGs without even telling us – they'd never do that to us now. (LD2)

But other GPs wished to go beyond having an input into decisions on care management processes to actually influencing the consultants' decisions on clinical practice, (see also the later discussion on the parties to the agreement of medical guidelines in the section on "Money and medicine"):

...For instance we've built the use of certain anti-coagulants before certain operations into contracts – it means far less chance of thrombosis – which can be life-threatening if it reaches the patient's lung – we've known about it for years and it's very cheap but very few

consultants were actually doing it... They thought when they were given a consultant's job they were deified on the same day. (GD1)

Quality in contracting, that's what GPs are in fundholding for but consultants aren't very good at regress [providing less treatment when more may not be beneficial]. For example, for lung cancer all the research shows that on radiotherapy three doses is all that's required – any more than that just doesn't do any good but people [the consultants] are still using seven to eight doses, so money's being wasted. (GD1)

Some GPs suspected that the hospital Trusts were responding to GPs' increased financial leverage by increasing the number of cross-referrals between specialisms, in order to generate income:

There's a triumvirate of orthopaedics, neurosurgery and the pain clinic. They make referrals between themselves and there's nothing we can do about it when we get billed... The other way they've got of making money is combined clinics – we send a detailed letter and they pick something out of it ... There's no doubt that the Trusts are looking to make money and they're using various means of doing it. ... We send a patient in for a surgical procedure – a day case – and then someone comes and sits at the end of the bed – that's an out-patient appointment and we get charged for both – they say an out-patient appointment has taken place. (TD2)

These accounts of the restructuring of professional relations in the NHS have indicated how GPs with jurisdiction over money have used this leverage to improve, from their perspective, the processes of case management at the interface with the hospitals. Such perceptions reflect the findings of Dixon (1993) and Glennester (1994). These improvements encompassed the re-establishment of communicative links between hospitals and surgeries: face-to-face meetings between GPs and consultants where medical agendas are discussed; discharge letters which gave accurate information about in-patient episodes; and reduced waiting times for consultant diagnosis of patients' conditions. In addition some GPs have gone beyond this in an attempt to influence consultants' clinical practice.

There were signs of reactions to the enhanced power of GPs as the "empire strikes back" (Glennester *et al.*, 1994, p. 106). When "money follows patients" through cost and volume or cost per case contracts, there are incentives, first, to treat rather than to wait and see and, second, to cross-refer (to increase the number of items which can be billed). The experience of the USA has been that when fee-for-service is the norm the importance of peer review bodies is heightened in order to assess the appropriateness of medical interventions and to bring pressure to bear on those who seem to be overly interventionist. In the current British context, although individual consultants are salaried, the quasi-market imperatives of hospital Trust status create financial incentives to intervene and also to fragment treatments between different specialties. Some fundholders had attempted to curb this practice by refusing to pay for tertiary referrals when the GP concerned had not been informed in advance that such referrals were clinically indicated. However, as it is unknown for GPs to question a consultant's judgement over such referrals, registering with the GP merely allows tertiary referrals to be monitored – it does not prevent them occurring. The issue of tertiary referrals illustrates that GPs still lack control

over medical processes once their patients are admitted into the hospitals. But fundholding offers opportunities to cut down on the referral rate and retain patients within primary care. GPs can use the financial flexibility conferred through fundholding, first, to challenge the dominance of hospital-based treatments by providing more holistic and/or preventive care and, second, to take back some of the more minor surgical procedures by providing them in-house. Both of these strategies, but particularly the second, can reduce the referral rate to the hospitals – lessening the dependence of GPs on consultants, enhancing the profile of GPs in British medicine and ensuring that more resources remain within primary care. The next section discusses these issues.

GPs use fundholding to expand the services provided through primary care and “take back” procedures from the hospital consultants

The flexibility that fundholding provides has allowed GPs to develop their professional practice. Many fundholding GPs now provide a much wider range of medical services within their surgeries than was previously the case – from physiotherapy, chiropody and various forms of behavioural or cognitive therapy to a range of services from complementary medicine:

There's a lot of physio needed in this area and, as we've spent less on drugs, we've been able to transfer the savings to physio. (TD2)

We've got cognitive/behavioural therapy, there's a group of patients – say depressive or phobic ... you couldn't crack that in seven minutes or you spent an hour and it came off another patient's time ... now we've got the CPNs [community psychiatric nurses] they've got the time ... there's a lot of unmet need ... there's a whole lot of patients who you wouldn't necessarily refer on but they need time, it's meant the quality of service has improved tremendously – now they don't have to wait. (TD1)

We have a community care co-ordinator – we wanted to make social work really work. Our teenage health clinic covers everything from spots to sex. (TD1)

The patients get a better deal, we've got more in-house servicesand we've introduced complementary medicine – a medical hypnotist, aromatherapy and massage, and reflexology – we've always had an interest in it. (TD2)

Within this expansion of primary care the most significant professional development has been the re-emergence of the GP surgeon as this may challenge the consultants' monopoly over surgery as a work task (Abbott, 1988, p. 118). All three of the regions in Scotland in which the research took place had access to the services of a GP surgeon and in one of these regions both the surgeon and the lead fundholding GP in the practice were interviewed. The lead GP emphasized that the service must be credible in the eyes of the local consultants:

Well if you've [the hospital Trusts] got a service which can't cope and we're offering a true blue accredited service, what can they say? But you've got to be careful about secondary care in primary care – if it's at a hobby level then you're doomed – you've got to be credible at the consultant level. (GD2)

Initially credibility was low, as judged from the reactions of the surgeons at one local Trust:

Do you know what they said? They said "Do you want to send your patients to a failed surgeon?", they [the consultants] actually said that – the arrogance of that. (GD1)

In the event the GP surgeon interviewed dissipated the initial adverse reactions of local consultants by "going to them for protocols". A protocol of care establishes a predetermined schedule through which the treatment of a medical condition can be organized; therefore it allows delegation to a more junior clinician or to a nurse (Marsh, 1991, p. 42). That this GP surgeon went to the local consultants for "protocols" implicitly acknowledged the continuing power of these consultants to oversee her surgical list. Even though the work had been transferred out of the hospitals, the consultants' control over this minor surgery was not completely curtailed:

I'd anticipated problems with the consultants but I went to them for protocols and ideas and there hasn't really been a problem; mind you, I've been very careful, I was aware that our heads were on the chopping block – that some people would be very pleased to see it all go wrong. (GD3)

This approach to the consultants by the GP surgeon put her in the position of a junior member of the consultants' firm and ensured that her clinical practice did not conflict with their established procedures – thus consultants continue to maintain jurisdiction by maintaining influence over lesser colleagues from their heartland in the hospitals (Abbott, 1988, p. 119). One GP argued that the emergence of the GP surgeon did not undermine the consultants' control over surgery:

They're [the consultants] not threatened clinically, these minor ops are done by housemen or SHOs [senior house officers], anyway, they're not done by consultants. But if it takes money out, they don't like it, if they see their financial empires shrinking – that worries them, I think. (LD2)

The possible financial implications of a reduction in income for the hospital Trusts were highlighted by the demand for the services of the GP surgeon exceeding expectations:

It was slightly frightening and I'd only anticipated a couple of hours a week – but I do a full day – I could do two days if I wanted to. (GD3)

The GPs at this practice had recently attended a fundholding meeting which had considered the merging of primary and secondary care in a single building – such a scheme had been recently established in England:

There's a unit in England where the GPs bought the hospital – the ground floor's primary care and the first floor is secondary. The GPs bought in expertise from a Trust at a distance – the local one wouldn't do it – the GPs provide the post-operative care. We could use the community hospitals in this way – it fits the Patients' Charter – the one near here is run by the local Health Care Trust, but they don't own them, they have a franchise to operate from them. (GD2)

The preceding two sections have outlined how fundholding GPs have sought to reduce the power and status differentials between themselves and the consultants, first, by increasing the communications between the hospitals and GPs' surgeries, second, by expanding the range of services offered within primary care, and third, by "taking back" procedures from the consultants in the hospitals. Task and workplace differentiations (Abbott, 1988) are diffused through these means. The merging of primary and secondary care in one building would consolidate these processes as GPs and consultants would no longer be aligned with separate work sites and the old "cottage" hospital would have re-emerged in a new form. Nevertheless consultant status remains something to be aspired to rather than attained and GPs remain in the shadow of their more powerful colleagues. This is demonstrated by GPs importing the medical conventions of the hospitals into general practice in an attempt to align the two workplaces. GPs speak now of having "specialisms" (TD1) in "general" practice through their expanded range of services and of new GPs being "registrars" (NF1) whom the longer established GP partners train. GPs also acknowledged the continuing relations of dominance in medicine by asking the consultants for "protocols" for minor surgery and ensuring that they were "credible" (GD2) as GP surgeons in the eyes of the consultants at the local hospitals. But because fundholding constitutes a facet of the quasi-market in health care, it forces both GPs and consultants to engage with managerialism in medicine and, as potential managers, GPs have some advantages over the consultants as the following section demonstrates.

GPs as doctor-managers use fundholding to marginalize "lay" managers in the hospitals and the Health Boards

There has been a shift in government policy from the attempts in the 1980s to strengthen management in health care (as operationalized in management budgeting) and thereby control health professionals (Packwood *et al.*, 1991; Pollitt *et al.*, 1988; Preston *et al.*, 1992) to a strategy of creating managers out of these professionals (Hunter, 1992, p. 565). This change in emphasis saw Tayloristic strategies of management budgeting give way to the "new wave" ideas of resource management within the hospitals (Walby and Greenwell, 1994b). The dominant position of clinicians within the NHS sets a context where moves to make doctors into managers will be successful only where doctors can see professional benefits accruing through the process. Lead fundholding GPs are becoming managerialized because fundholding is conferring real professional rewards (status, power and perceptions of improved quality of patient care) on participating GPs. Where the management or administrative tasks of fundholding are operational or comparatively routine in nature, GPs have delegated these tasks to predominantly female practice (or fund) managers, echoing the findings of Laughlin *et al.* (1994) where unwanted mundane clinical tasks associated with the GP contract were passed on to practice nurses. Thus the managerialization of the GP practice through fundholding has not involved a threat to the continuance of GPs' core

professional practice with patients (see the discussion in Llewellyn and Grant, 1996 on the impact of fundholding on the clinical dimensions – consultations, prescribing and referrals – of primary health care). Moreover practice (or fund) managers occupy a clearly subservient role to GPs and do not challenge their dominant professional position. But this is not the case for consultants, as “management” within the hospitals has been a domain occupied by a separate professional cadre and this group have posed a threat to consultants’ clinical freedom (Hunter, 1992). These differences in the managerial context within general practice and the hospitals impacted on the initial round of contracting in this study. In the beginning the consultants stood back from the contract negotiations with the GPs – leaving the process to hospital managers. This resulted in managers agreeing unrealistic targets and standards from the clinicians’ point of view. One GP commented on their first round of contracting with their local Trust:

We agreed standards with the managers but they hadn’t even shown them to the clinical directors. They were so keen to get the money. Later I saw one of the clinical directors in the corridor and I said to him, “This is what you’ve signed up to.” He said, “We can’t do that – that’s impossible”. I said “Well I know that but your managers agreed it”. They were in breach of contract for six months but we didn’t press it. There’s a lack of communication between the managers and the clinical directors, so now we only go to meetings when the clinicians are present. (LD1)

Managers aren’t the point – OK the consultants don’t always agree and that’s the real problem. But having managers in the middle just makes things worse. (GD1)

Moreover, as managerialism is generic in its terms of reference, GPs believe that managers (particularly if they have been imported from outside the NHS) fail to understand the particular nature of the British NHS, specifically, managers do not grasp that change within the NHS has to be slow:

They [management in the Trusts] get in these contracting guys – they’re straight out of Japanese computer firms – they don’t understand – it’s [the NHS] not like business, it’s a huge dinosaur. (LD1)

Pre-1982 change was slow within the NHS as, during that period, change in the NHS was incremental (Harrison and Pollitt, 1994, p. 36). Incremental change, in turn, reflected the dominance of consultants, as providers, in shaping the NHS and ensured the continuance of the provider values of paternalism, planning, need, trust and stability (Klein, 1995, p. 248). Post-1982 incremental change in the NHS was disrupted, first, by the attempts to control clinicians, through strengthening management and imposing budgets, and, subsequently by the strategies to create managers out of doctors through offering them budgets (Hunter, 1992, p. 557). GP fundholders, who have become managerialized, clearly believe that doctors rather than managers should decide priorities and make resource management decisions. GPs think that managers lack insight into the nature of clinical practice (they sign up to “impossible” clinical standards) and are driven by purely financial criteria (“They were so keen to get the money”). This leads to strategies to marginalize managers (“They aren’t the point”) by only going to meetings when fellow clinicians are present. This

understanding underpins the seemingly paradoxical position of the GP who, while emphasizing the changes wrought by GPs at the interface with the hospitals, still maintains that the NHS is a “huge dinosaur”. An understanding that GPs and consultants both have a stake in maintaining provider values explains the perception of this GP that the NHS is a “huge dinosaur” which managers “don’t understand”. Fundholding GPs wish to instigate change in the NHS but they want change to be negotiated within the medical profession rather than allowing extraneous management criteria to drive agendas.

Fundholding has enhanced communications between GPs, as purchasers, and consultants, as providers, and has therefore been a vehicle for marginalizing the role of hospital managers in contracting. But the marginalizing potential of fundholding is even greater with respect to the managers in Health Boards as the reforms introduced GPs and Health Boards as budget holders with overlapping purchasing roles. Prior to the health service reforms, Health Boards had held sole responsibility for the co-ordination and delivery of health care but post-reform Health Boards now have a much more limited purchasing and planning role. These overlapping purchasing roles immediately created an open question as to who would emerge as *primus inter pares* in contracting (Culyer *et al.*, 1990). In the three-way relationship between the Trusts, fundholders and the Health Boards, GPs were divided in their opinions on the future role of the Health Boards. Although all GPs felt that fundholding has marginalized Health Board functions to some extent, some thought that the Health Boards had a future in strategy and monitoring whereas others were of the view that the Health Boards were likely to become defunct. The following comments illustrate the view of a GP who was, broadly speaking, supportive of the Health Boards:

We have a visionary Board but some Boards don’t want to let go. Our Health Board no longer goes for everything, they set the strategy but the GPs do the purchasing. There are now 32 fundholding practices in this region. There are three members of staff employed by fundholders who are situated in the Health Board. With an executive manager this could form an agency. Such an agency could do the purchasing for the fundholders and the non-fundholders. (GD1)

But others were dismissive over the negotiating skills within the Health Boards as this remark shows:

We negotiated with the Trust and got our contract. Then the Health Board went in and got less – so then the Trust turned round and said we can’t agree what we’d negotiated – they [the Health Board] were dragging us down. (LD1)

Furthermore some GPs felt that the future viability of the Health Boards was severely in doubt:

Well the logical conclusion [of fundholding] is that there won’t be a Health Board. (TD2)

The Health Boards concede that GPs are purchasing but they say that they are quality, strategy and public health but they are punk at strategy. What’s strategy without purchasing? Strategy independent of purchasing is a nonsense...but they [the Health Boards] are fighting back – they are relying on two things – one waiting for an election and, two, reining the

fundholders in .. [but, presently] ... The Scottish Office [central government] wants Health Boards out of purchasing. (TD1)

The enhanced communication between hospital doctors and GPs wrought by fundholding has defused the management threat (in the Health Boards and the Trusts) to doctors' jurisdiction over the planning and control of medical agendas by "squeezing" the role of management in negotiation. Fundholding GPs are being managerialized as they believe that the processes of holding budgets and managing resources are genuinely helping them to become better doctors. This message has been difficult to communicate in the hospitals where there has been a split between professional and management cultures (Hunter, 1992) but, within general practice, where GPs have always functioned as "independent entrepreneurs" (Stacey, 1988, p. 124) of healing, processes of creating doctor-managers have been much more successful.

If doctor-managers become a dominant group, then this will have profound implications for "lay" managers, "... in particular will they return to the days of being the handmaidens to powerful clinical 'bosses' but under a new guise?" (Hunter, 1992, p. 559). A focus on "better" ways of allocating resources enhanced the role of managers as potential co-ordinators and planners of health care. This created an opportunity for managers to invade the territory of professional medicine through their claims to more effective means of rationing and distributing health care. But the purchaser/provider split (of which fundholding formed a part) handed over "planning" activities to the logic of the quasi-market. Within this market GPs have occupied a more autonomous role than their consultant colleagues. Hence, so far, GPs have been better able than the consultants to defend medical agendas from a managerialism which has threatened to break out of its administrative framework to challenge the medical dominance of decision making over resource management in health care.

However, GPs' enthusiasm for resource management may diminish if and when overall resource constraints begin to bite and there is some evidence of this beginning to happen. A "cash crisis" for fundholders was recently reported in one of the regions involved in this study. For the first time fundholders in this region refused *en masse* to accept the budgets allocated by the local Health Board claiming that, "... the proposed funds are insufficient to meet 'massive' price rises by two of the city's Trusts...", the finance director at the Health Board retaliated by stating that "Clearly the issue of prices being charged by individual Trusts is a matter between the Trusts and the fundholders." (*Scotland on Sunday*, 12 May 1996). This incident highlights the power of the Health Boards to pass questions on the overall adequacy of resource funding back to the logic of the quasi-market, to be solved through negotiations between GPs and the Trusts. Moreover GPs' new-found role in resource management is not unidimensional – it is dependent on the projects which GPs are seeking to realize. It is this source of uncertainty which the next section discusses.

Money and medicine: interwoven agendas

The preceding sections have explored three areas where there is a dynamic relationship between GPs and consultants consequent on the fundholding initiative. This section now moves to focus more closely on the diversity of approach to the development of fundholding taken by GPs themselves who, although they may have been motivated to “go fundholding” in the first instance by a common desire to redress the balance of power between themselves and the consultants, now seek to realize different projects. That there is space within the fundholding initiative for various projects to be pursued is linked to the ambiguity which surrounded the initiation of the scheme.

The intended policy impact of fundholding was ill-defined and, consequently, the structural mechanisms of fundholding are not yet finalized. As one GP remarked:

No one thought through what it meant or what it was intended to achieve, basically it was dreamed up by a GP on drugs who sold it to Margaret Thatcher [the then prime minister] at a dinner party. (NF2)

Mrs Thatcher seized on the idea of GP budgets with some enthusiasm at a point in time when there were fears of the government “losing their way” on the health reforms. (Klein, 1995, p. 190). Thatcherism had constituted these reforms “... as a continually unfolding project, with policies being dropped, adapted or invented to suit the circumstances.” (Humphrey *et al.*, 1993, p. 11). Fundholding was an ingredient in this “reform cocktail” (Klein, 1995, p. 191) whose likely effects were unpredicted and somewhat unpredictable. This ambiguity created “conditions of possibility” (Latour, 1987) within fundholding for differing projects to be pursued which, in turn, implies differential responses to the accounting mechanisms inherent in fundholding. This section explores GPs’ responses to budget setting, to the use of audited “savings” and to the medical audit of general practice. On the initial setting of the budget, where GPs favoured using budgets to enhance equity within the NHS they pressed for capitation-based budgets. In contrast, where they were more concerned with extending primary care services they emphasized the incentives provided through the use of historic spending patterns. GPs concerned with the issue of equity in resource distribution in the NHS commented:

It’s [budget setting] not an exact science, well that’s the understatement of the year – there are winners and losers – we came out about the middle but we had good quality or honest data – until there’s an agreed capitation formula, equity will be noticeable by its absence. (GD2)

I’m opposed to the way funds are made up. It should be weighted capitation rather than the historic basis. We’re always complaining about spendthrift practices – under this system they keep getting more and more money – maybe they’ve referred excessively to the hospitals. I want to use this system to restore some of the inequities in the Scottish Health Service... For instance, there’s two practices I know, they both get £190 per patient – one’s in a deprived area, so you can understand that, but the other is in a very prosperous area but they say, “We’ve got a lot of professional people here and they like second opinions”... I ask you was that why the health service was set up – to provide second opinions?... It’s a nonsense. (GD1)

must be seen to be linked to efficiency gains through purchasing in order to have a chance of political approval. The notion of “efficiency” rewards invokes the possibility of performance evaluation for clinicians, which, in turn, is linked to medical audit. The idea of medical audit (both for the assessment of good general practice and for effective purchasing) was raised by a number of GPs. However, they were divided as to its efficacy and general desirability. This first quoted GP intended to undertake an avoidance strategy:

Medical audit – now that’s a nasty word. I think we give a reasonable service to our patients – if they were jumping up and down, we might just look at it but, frankly, we avoid it like the plague. (TD2)

Whereas another GP regarded audit as essential to safeguard public money:

We should have a medical adviser to go around checking what people [GPs] are doing ... We’ve got a prescribing adviser but that’s just for prescribing. There should be a way of dealing with profligate spenders – it’s all about the proper use of public funds – they’re writing a cheque for public money that may not need to be written. (GD1)

Still another GP distinguished between “clinical” audit and accountability for purchasing:

Most doctors are keen to participate in clinical audit but accountability for purchasing scares the life out of me – accountability frameworks are frightening. But we do need to look at ways of working and prescribing. (NF1)

As in the preceding discussion, purchasing was again a vehicle for enhancing GPs’ control over consultants – in this instance GPs were specifying particular guidelines (which had emanated from medical research of consultants’ clinical practice) in contracts:

The growth industry in medicine is guidelines and fundholding has enabled us to build into the contract exactly what we want. We’re trying to use guidelines to change clinical practice then they [the consultants] can’t weasel out of it – but the trouble is they won’t listen unless some of their peers are doing it. They weren’t going to have someone telling them what to do but the guidelines are supported by SIGN [the Scottish Intercollegiate Guidelines Network] so now it’s very different – even the medical colleges approve. It means we are getting best practice as codified by the experts and we expect it. (GD1)

Research on medical audit within the hospitals indicates that the process has been defined as one of medical self-management – particularly in the education of junior doctors by consultants. Out of 55 audits examined by Kerrison *et al.* (1993, p. 164) 18 did not specify any criteria for the audit and, for those that did, the criteria were technical in nature; moreover only 3 per cent used any cost data. So far the accountability of the medical profession has not been significantly enhanced by the audit experience – with the exception of the accountability of junior doctors to their seniors (Kerrison *et al.*, 1993, p. 169). This indicates that there is considerable potential for the accountability of consultants to be heightened through their contractual relationships with GPs.

These issues relate to what would be a profound change in British medicine: the introduction of constraints on the clinical freedom of medical professionals. Clinical freedom encompasses a number of medical prerogatives: decision

making by individual clinicians unconstrained by protocols or guidelines; the right to make clinical decisions which result in resource allocations without reference to costs; and adherence to a medical ethical code which is dominated by individualistic rather than societal concerns. The use of medical protocols and guidelines through the introduction of medical audit (particularly where such audit makes reference to costs) is intended to render clinical decision making more transparent. More open scrutiny of the processes of medical diagnosis, inference and treatment would reveal levels of professional uncertainty and expose the lack of medical knowledge on the comparative efficaciousness of alternative treatments for certain conditions (Katz, 1988). In medicine uncertainty has been absorbed at the expense of the patient rather than the clinician (Johnson, 1972, p. 41). Where levels of professional uncertainty are present, but not publicly visible, clinicians have been able to define their work so that "failures" are not apparent. In this way the medical profession used the germ theory of illness to minimize its failures with chronic conditions such as arthritis, heart disease and cancer (Abbott, 1988, p. 136).

The definition of success is particularly significant to a profession, involving, first, powers to define what is and what is not a "problem", second, the measurement of the treatment of problems and, third, the evasion of external judgements over the comparative efficacy of treatments through arguments about differential circumstances (Abbott, 1988, p. 137). Where GPs press for guidelines in contracting, their control over their consultant colleagues is enhanced but, as in overall contract negotiation, the closer communication between GPs and consultants (necessitated by their agreement on guidelines) may imply that control is not lost through audit to external groups such as lay managers. On the other hand, where guidelines routinely connect diagnosis directly with treatments, this will diminish the role of inference. Abbott (1988, pp. 48ff) argues that inference (or professional thinking) makes connections between professional knowledge, client characteristics and chance. Inference is a middle game which relates diagnosis to treatment in ways which are known only to clinicians and keeps uncertainty hidden within the realms of expert thinking. Hence where inference is essential, routinization cannot occur and there is less likelihood of the professional group losing control of the work to outsiders. If the introduction of guidelines results in the routinization of substantial areas of medical work, then control over this work may well be lost to managers.

Fundholding as a social structure retains "emergent powers" (Sayer, 1992, p. 118) in the sense that, although all fundholding GPs are involved in a structure of exchange with the hospitals and are constrained in some respects over how they employ their budgetary responsibilities, they remain able to realize different projects (Giddens, 1984, p. 6) through fundholding. These plans are complex (and sometimes overlapping) but nevertheless certain distinct programmes can be identified. The powers over resource allocation which fundholding confers can be used, first, to enhance equity and enable accountabilities through capitation-based budgets, the return of any unplanned

savings to the public purse and the practice of medical audit or, second, to “empire-build” by advancing and diversifying on-site primary health care services through seeking to establish generous historic funding levels and retaining “savings” in-house, while shunning audit practices which may expose any inequities in allocated expenditure. The evidence from this study indicates that the outcomes of a closer alignment between money and medicine are not fully determinate and are being shaped by the political aspirations of doctors as they use accounting-based measures, such as budgets, to seek to achieve differential projects within medicine.

Concluding comments

The National Health Service is a great British icon symbolizing national pride and unity, “... foreigners come from all over to get it free ... [it brings together] ... consultant aristos and ward angels; the dialectic of death and deliverance, stern father, healing mother.” (*The Guardian*, 17 June 1995). As an organization with such high standing in public affection and esteem the NHS is peculiarly resistant to change – trading on its reputation as Britain’s only immaculate institution (Klein, 1995, p. 229). Clinicians also possess a certain fascination for the public; they have a “mystery” not only in the medieval sense of belonging to an exclusive occupational group but also in the sense of sharing secret esoteric knowledge (Corfield, 1995, p. 20). “Medicine, after all, was born in magic and religion, and the doctor-priest-magician-parent unity ... persists in patients’ unconscious.” (Katz, 1988, p. 556). Myths of unity have masked considerable professional tensions, both within the medical profession (as described here) and between different health professions (see Walby and Greenwell, 1994b, on the conflicts between clinicians and nurses). Presumptions of the NHS as a unified entity has fostered policy prescription which has understated the contrasts (in terms of organizational performance) which exist between different organizational units, for example, emergency treatment and waiting list (or “cold”) surgery (Walby and Greenwell, 1994b, p. 167). Fundholding harnessed the professional discontent of GPs and brought it to bear on particular areas (such as elective surgery and out-patients) where competition was feasible and delays were common. Hence the early standard fundholding option was focused on those parts of the NHS where there was potentiality for improved responsiveness. Emergency health work provides the “crisis” ethos which generates a high level of goal congruence (Walby and Greenwell, 1994b, p. 167), as medical staff put aside self-interest to work on “life or death” critical cases. In the non-emergency sectors of the NHS such work incentives are absent. Consultants get little satisfaction from routine surgery and, for those with private clinics, there is a positive incentive to maintain waiting lists to encourage patients to “go private”; as out-patients are frequently seen by a junior doctor, the easiest option is to carry out a routine check-up and make the patient another appointment when the particular junior will probably have moved on to her/his next post (Glennester *et al.*, 1993).

Routine surgery and out-patients constituted areas of under-performance for the NHS and the accounts of agency related above rationalized how and why GPs sought change in these areas. Purchasing power, conferred by budgets and enacted through contracting, enabled GPs to enhance performance in elective surgery and out-patients by improving care management processes, introducing guidelines for clinical practice and "taking back" some minor surgery into primary care. There is cross-party recognition of these facets of fundholding, the Labour party document "Rebuilding the NHS" leaked to *The Independent* (16 June 1995) stated that, "We fully recognise that there have been benefits [from fundholding] in terms of responsiveness and change". *The Independent* reported that, although intending to phase out fundholding in its present form, "...Labour is keen to see GPs given notional budgets that would allow them to switch spending not only between drugs and other treatments, but also between health and social care."

Changing the mode of governance of the NHS to a more market-based approach reopened the "channels of communication" (Ezzamel and Willmott, 1993, p. 128) between GPs and consultants by re-establishing monetary exchanges between them. Polarized medical professionals were reconnected through the medium of contracting. Consultants will now travel to GP surgeries to conduct "outreach clinics"; regular meetings act as an intra-professional forum for the discussion of processes of case management and clinical practices in secondary care. In these areas:

Consultants show more interest in our opinions – that's a big change. (LD2)

The possible development of integrated primary/secondary care settings would further narrow the differentials between GPs and consultants and, as outlined above, the community hospitals present as opportune sites for such initiatives. Fundholding GPs perceive that these developments were achieved only through the threat of loss of income for the Trusts:

If it takes money out they [the consultants] don't like it, if they see their financial empires shrinking – that worries them, I think (LD2)

Abbott (1988, pp. 3ff) theorizes the division of expert labour through the process of jurisdiction, where sequences of jurisdictional control occur. The introduction to this paper outlined how GPs lost jurisdictional control over medicine through the following processes: the task specialization which confined them to a gatekeeper role; their exclusion from the hospitals; their lack of involvement with the central professional knowledge base; and their static career pattern. When asked about their initial reasons for taking on fundholding, GPs emphasized the issue of enhanced control over medicine:

To put control back into general practice, to be in charge of our own decisions. (LD1)

To let us take in our own hands the levers to change things, to give us control over our own destiny, to enable us to deliver better primary health care to patients. (TD1)

Polarized professionalism in medicine created a division of interest between the GPs and the consultants – with GPs occupying lesser power positions across

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this divide. GPs used fundholding as a medium
between themselves and the consultants. But
alignment between money and medicine thro
determinate. The ambiguity within the scheme
projects, demonstrating, first, the considerable a
the health reforms in particular ways (Laughlin
emphasizing that myths of unity within the
projects were identified above as, first, the enab
allocations between GP practices, second, th
offered within practices and, third, the possibil
GPs delivering greater "efficiency". If budg
stringently, then the second and third of these
fears of those GPs who see the scheme as essen
buck" over rationing would then have been rea

Some GPs don't trust it [fundholding]; they say it's
money now but later they'll [the government] rein it in

This paper has identified GPs' professional d
position in medicine as a powerful impetu
fundholding but once GPs embark on the sche
This differentiation implies that the future of fu
complex dynamic dependent on how far GPs' p
with (or divorced from) the developing struct
However, the focus of this paper has been o
renegotiation which has accompanied the re-es
over money in the British National Health Serv
the accounts presented here have explored.

Notes

1. Laughlin *et al.* (1994) discuss the managerial relatio
Authorities (FHSAs) and GP practices in the English
a different form – they are termed Primary Care Dep
Boards.
2. Six-hundred cottage hospitals were dotted about the
3. There are other factors which are involved in Britain
the existence of nationally negotiated, tightly con
labour market and, second, the absence of profit/ap
which are passed on as costs.
4. Britain ranked 20th out of 21 European and North
expenditure on health care (as a percentage of GDP a
of Health Statistics, 1992, quoted in Harrison and Po
5. Although a shadow year for gathering data on hi
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much shorter periods, for example, three to four m
evidence of abbreviated shadow exercises (see for e

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BOUNDARY WORK: COSTING AND CARING IN THE SOCIAL SERVICES

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Abstract

"Where does it stop on costs?"—this paper offers some responses to this question on the appropriate boundaries for costing expertise. The question was posed by a contracts officer within a social services department. The context for the question was an empirical research study in which front line welfare professionals were asked to comment, first, on costing information which could, possibly, assist in making "value for money" assessments and, second, on the contracting regime within which such costing information assumes a potentially highlighted significance. At the first stage of the study welfare professionals were found to be engaged in boundary-work to prevent the encroachment of costs on care activities. "Costing" and "caring" were being managed as "disengaged domains" through the boundary work of obfuscation, "reality-defining" and marginalization. Consequent upon the initial study the social services departments were re-visited two years later. By this time it was apparent that boundary-work had allowed some engagement between costing and caring. The paper argues that processes of alignment between costing and caring and the reconstitution of organizational tasks (including the creation of care "managers") have allowed social work professionals to accept some costing work—work which had previously been defined as "the other". The major themes of this paper are: the exploration of the responses of operational social services personnel to their new financial roles, and the interpretation of change in the social services context through the ideas of boundary-work. These themes are developed through a consideration of the ambiguous tasks of welfare-professionals and the consequent indeterminacy of resourcing decisions. The paper concludes that the limits of applicability of costing are yet to be set in the domain of the social services. © 1998 Elsevier Science Ltd. All rights reserved.

Organizational change is expressed through the dissolution and reconstitution of organizational boundaries—through the processes of blurring, crossing and permeation (Klein, 1993). Boundaries serve, first, to differentiate mutually-defining points of view (Cooper, 1990) and, second, to shape domains by controlling the types of difference permitted within them—thus preventing fragmentation (Messer-Davidow *et al.*, 1993). A number of different

organizational spheres give rise to boundary-work: within organizations, boundaries define internal domains of professional expertise or competence (Gieryn, 1983); boundaries demarcate the external limits of the organization legally and financially; and they also mark the organization's span of control (Pfeffer & Salancik, 1978). Boundary-work reproduces the organization as an ordered entity (Llewellyn, 1994).

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This paper has a specific focus on the changing constitution of the distinct boundaries of two types of expertise in the U.K. social services, those of "costing" and "caring". "Costs" and "care" are cited here as the "entry points" (Amariglio *et al.*, 1993, p.164) to the discourses of public sector accounting and social work practice. An entry point, although not necessarily the ultimate truth of any discourse, is the central concept from which that discourse flows and is also the concept which will shape the asking of all questions within the discourse.¹ Boundary work (Gieryn, 1983) to reconstitute a domain must address its entry point as an entry point is used to define the limits of a domain and also serves to discriminate between activities which are taken to be appropriately intrinsic or extrinsic to the domain in question (Amariglio *et al.*, 1993). Thus "cost" has negotiated the limits of public sector accounting, and "care" has distinguished what is or is not appropriate to social work practice. The paper explores the shift in the social services between the boundary maintenance which has separated "costing" and "caring" (preserving professional autonomy and discretion in social work practice) and the boundary-work to integrate "costing" and "caring" (demanded by public sector accounting).

There is some continuity in the ideas of boundary-work (to distance costing from caring) with Weick's (Weick, 1969, 1976) classic work on loosely-coupled systems². This work was somewhat underspecified and the explanatory value of the concept of "loose-coupling" has remained unclear (Orton & Weick, 1990). The analysis of boundary-work extends Weick's thesis by exploring how the separateness of loosely-coupled systems is maintained and, conversely, how and under what circumstances loosely-coupled systems come to be more closely aligned. Particular observations on

loosely-coupled systems are relevant to this analysis: Weick cites Glassman (1973) as arguing that loose coupling lowers the probability that the organization will have to (or be able to) respond to changes in the environment; loose coupling also seals off parts of the organization from pressures in other parts and, hence, within the "sealed off" parts, enables enhanced scope for the self-determination of organizational actors.

Change, through the integration of previously loosely-coupled systems, involves the disruption of boundaries as new organizational structures, processes and meanings emerge. Therefore, although boundary-work is often of an ideational form, it also has significant strands of power and arbitrariness (Messer-Davidow *et al.*, 1993). The paper looks at the pressures for change in the personal social services where, historically, there have been powerful institutional incentives (see the discussion below) to create boundaries around "costing" and "caring". These incentives have fostered active boundary-work in order to distance caring activities from costing information and, in consequence, to maintain the autonomy of "caring" (Gouldner, 1959). But the rationalization of the public sector is threatening "distancing" by introducing an ideology of cost effectiveness and, thereby, creating inducements for some linkages between "costing" and "caring" within operational decision-making processes. Although allocative control of the overall funding of the social services has made reference to functional costs, "organized anarchy" (Cohen & March, 1989; Willmott, 1990) has been the experience of operational social work professionals as "costing" and "caring" have constituted diverse organizational practices. As "organized anarchy" comes under threat the paper explores the alternative possibilities invoked by a possible re-alignment of costing information within the decision-making

¹Amariglio *et al.* (1993) illustrate this concept by siting class as the entry point for Marxian economics and individual preferences as the entry point for neoclassical economics.

²Weick's work on loosely-coupled systems was in the tradition of Lawrence & Lorsch (1967) in so far as it argued that processes of both integration and differentiation were fundamental to organization.

processes of front-line welfare-professionals in the social services.

Maintaining boundaries around "caring" prevents the conflicts engendered by the encroachment of costing information on "care" as the core valued activity of the social services. Accounting "... engenders resistances to the strategies and interventions which it seeks to further." (Hopwood, 1987, p.230). When asked during the first part of this study (described in detail later in the paper) if cost calculations ever entered into decision-making on care in the community one contracts officer responded as follows,

"There might be hidden costs to the carer... and she might end up in care herself and that would be expensive... on the other hand the burden on the carer might be such that she died earlier and that would be cheaper... where does it stop on costs? (R1/C)."

This response articulated the essential indecision, consequent upon a lack of knowledge about consequences (Weick, 1976), which is faced by welfare-professionals. Costing information circumvents these perceptions of complexity and ignores the ambiguity of consequences as the constitution and construction of costs forces the creation of decidables from indecision (Cooper, 1990). The response also raised the issue of the intrusion of costs into domains usually governed by the norms of professional judgement. As the contracts officer implies, the ultimate violation of these norms is committed if costs enter into decisions concerning "life and death" issues—the defining arena for claims to "pure" professional status (Etzioni, 1969, p.xii). This threatened infringement of accounting on caring activities has met with resistance and redefinition in other parts of the public sector (Preston *et al.*, 1992; Humphrey, 1994; Laughlin *et al.*, 1994).

This paper portrays a story of initial resistance in the social services where pre-existing ways of working and understanding continued to direct decisions and, also, serve so as to marginalize costing information. These rationalities encompass both the sum of self-interested, individualistic motivations and broader societal

purposes which flow from the "formative context" within the social services. This "formative context" blends institutional arrangements with organizational members' imaginative (or interpretive) assumptions to produce strong prescriptive notions over the "proper" nature of the rights and powers which structure social relations within the organization (Blackler, 1992). Economic decision-making in the social services is, therefore, "embedded" (Granovet-Granovetter, 1985, p.487) in social relations. Hence boundary-work to integrate "costing" and "caring" has to address the re-constitution of social relations in the social services.

The structure of social relations in the social services has been one where formal, quantitative calculation informed by costs is seen as dissociated from (or even inimical to) the carrying out of core, caring activities (Clegg, 1990, p.155; Morgan, 1990, p.23). Thus, within the social services, costs have been socially constructed as "the other" or as an outside force against which "carers" must unite to prevent invasion (Sugarman, 1995). Such was the context for the government's intent that the cost effectiveness of the social services should be enhanced (see the 1990 NHS and Community Care Act). This proposed reshaping of the social services linked the themes of cost inefficiency, ineffective management, the vested power interests of social work professionals, and a lack of responsiveness to users (Langan & Clarke, 1994, p.74). Integral to government thinking was the idea that many of these shortcomings could be addressed by, first, making the relationships between costs and activities more visible and, second, by the proactive management of services through reference to costing information (see, for example, *Squaring the Circle: Managing Community Care Resources*, The Accounts Commission, 1994).

Central to this new regime was the creation of "care managers". Existing social work professionals were renamed as care managers. This change of title was more than cosmetic, it performed boundary work by marking out a distance between traditional social work (as a

combination between assessment and provision by professionals) and the new managerialism (as the management of care services through assessment and contracting) (Langan & Clarke, 1994). Care managers were expected to follow a style of care management which mimicked the "social care entrepreneurship" model dominant in the United States; implicitly this approach implied a rejection of the possible "service brokerage" model (concentrating on advocacy) which would have had some continuity with existing practice (Phillips, 1996). There was also an expectation that care managers would assume budgetary responsibilities. The cost consciousness of care managers was anticipated to flow both from their awareness of budget limits and, also, from their new managerial personae. Care managers were expected to deliver "more for less" but also to challenge the "formative context" of the social services where operational decision making has made reference to professional rather than managerial values.

The empirical material in this paper explores how boundaries had dissociated costing from caring and, subsequently, how boundary-work has enabled some integration between them. The paper has two interlinked themes: the exploration of the responses of social services personnel to their new financial roles; and the interpretation of the change process in the social services through theories of boundary-work. These themes are developed through, first, considering how the tasks of welfare professionals are socially constituted to encompass a high degree of ambiguity and, second, analysing how this ambiguity creates uncertainty which, in turn, impacts on rationalization and resourcing. The paper then illustrates, through reference to the empirical data, why and how boundary-work has contained professional uncertainty in the social services before looking at how boundaries have been disrupted and reconstituted to allow the integration of costing information.

SITES OF AMBIGUITY IN THE SOCIAL SERVICES

Various sites of ambiguity can be located within the social services. Welfare professionals in the personal social services are also "bureau-professionals"³. They are located within bureaucratic structures and, consequently, the processes through which their work is carried out "... are based on Fabian assumptions about the proper combination of professional expertise coupled with the regulatory principles of rational administration as the means of accomplishing social welfare." (Newman & Clarke, 1994, p.22). Whether there is greater reliance on the bureaucratic or the professional elements of this combination depends, first, on the degree of cognitive (or expert) knowledge practitioners make reference to, second, on the ability of practitioners to convince society that they have a valuable product and, third, on the extent of the autonomy of practitioners from state control (Jamous & Peloille, 1970). Professionalization claims are more readily accepted where practitioners possess expert knowledge, where they have convinced the users of their services of their value, and where they enjoy autonomy.

For example, the institutionalizing of knowledge in people within the pre-eminent professions of medicine and law has remained relatively secure. Medicine and law, have constituted "... islands of power relatively unconnected with the major sources of political and economic hegemony in society as a whole." (Esland, 1980a, p.219). Thus, within medicine, rationalization has produced a set of licensed practitioners who control definitions of "treatments" through diagnoses which are based on an internally credentialed knowledge base. Clinical practice is no longer reliant on exchanges with the patient—through the taking of a detailed history of symptoms. Medical practice has increasingly dissociated itself from the patient as the doctor's gaze (and consequent

³The term bureau-professional was first used by Mintzberg (1993).

clinical inference) takes pride of place over what the patient reports (Foucault, 1973; Abbott, 1988; Armstrong, 1993). Through this structuring of the medical domain, many medical skills of diagnosis, inference and treatment decompose illness into technical specialisms which do not differ much between patients and, hence, which can be treated by standardized remedies irrespective of the patients' histories (Whitley, 1995). This professional knowledge base is trusted to the extent that doctors are accepted as the only "truth-tellers"⁴ about medicine. Uncertainty, within medicine, is denied through these means; uncertainty in the health service being absorbed at the expense of the consumer rather than the producer (Johnson, 1972, p.41). Private sector fees are available as indicators of value and, although, links between "costs" and "treatments" are contested in organizational resourcing decisions⁵ the public worth of medical care is not subjected to any fundamental challenges. In contrast, social workers have never commanded a fee for their services, thus no private sector benchmark exists for the price (or cost) of publicly delivered services and, importantly in a liberal democracy, there is no public signal of value made through monetary payments for what are deemed essential services.

In the social services claims to a cognitive knowledge base have rested upon practitioners' counselling skills derived from clinical psychology and small group sociology (Halmos, 1967, p.20). Yet social workers have never achieved full public acceptance for these skills, in part, because they work mainly with the inherently disadvantaged and thus successful "outcomes" are difficult to attain—social work clients are often seen as "losers" (Eddings, 1992) in competitive western cultures. Also social workers, unlike psychotherapists, do not enjoy any association with the higher status medical profession. That their cognitive knowledge base

suffers from charges of subjectivity is linked to their failure (unlike the more successful clinicians and lawyers) to deliver a publicly acclaimed "product" (Jamous & Peloille, 1970). Hence social workers have never captured the market for the more high status psychotherapy work practised mainly with middle class clients. Social service professionals work within state bodies and they act as "servants of power" (Baritz, 1960 quoted in Esland, 1980a, p.214) in so far as they are agents for the implementation of governmental decision-making. Thus their power and status are both fragile and tied to their association with government agencies. In terms of the tripartite typology of professional control developed by Johnson (1972), pp.45–46) where the producer–consumer relationship is governed by either collegiality, patronage or state intervention, the social services are characterized by the third form of occupational control and the state mediates both in the construction of the consumer "needs" to be served and in the manner in which these needs are met. However, this political function as "servants of power" for state agencies remains implicit otherwise it would threaten public acceptance of their interventions in the name of therapy. These circumstances combine to make the role of the bureau-professional ambiguous.

The ambiguous role of the bureau-professional is played out in their work which encompasses a care/control dynamic. In the realm of "caring", welfare professionals in the personal social services are distinguished by their claims to bring about changes in the personalities of their clients through insight. They aspire to expertise in the decoding and identification of various individual pathologies. Yet in those liberal democracies which revere personal liberty and integrity they must simultaneously claim that their inventions are non-directive (Halmos, 1970). The service orientation of social work is also feminized—as

⁴I am indebted to Maureen Sterling for the use of this phrase in this context.

⁵See Preston *et al.*, 1992 and Covalleski *et al.*, 1993 on the contested nature of the rationalization and resourcing of health care.

front-line staff in operational "lowerarchies" (Wildavsky, 1986, p278) have been predominately female (Abbott & Wallace, 1990). Feminine professionalism always carries ambiguities as,

"[It] is conceived primarily in terms of "nurturant power"...[and hence] does not carry the same legitimacy as that of the "traditional professional" in Western and indeed almost any known society. The "power of nurturance" is associated with the "private" and...female sphere, whereas the more prestigious public sector is dominated by men and typified in established professions i.e. medicine and law. (Lorentzon, 1990, pp.59-60)"

The power to nurture another person is linked closely with patriarchy which, in turn, is conceptualized as belonging to the private domain. Hence feminine professionalism conveys ambiguity as it transfers into the public sphere activities which belong "properly" to the private.

Whilst focusing their attention on individual needs, welfare professionals also seek to address the behavioural problems of their clients; problems which may give rise to various social "problems" or "pathologies". In containing these social pathologies the role of the welfare professional extends to social control. Such a care/control dynamic creates an ideological paradox which is constituted by the claims to be offering therapy and to be people—helping whilst working to readjust people towards social structures which may be contrary to their interests (Esland, 1980b, p.255). Integral to programmes of readjustment and therapy are the decisions made by bureau-professionals on the appropriate location of individuals within society. Taking a child into "care", committing an individual to a mental "hospital" or advising an elderly person to enter a "home" are all decisions about the "proper place" of these people in the management of risk both to themselves and to others. That these places offer therapeutic programmes obscures their other purposes both as centres which contain "difficult" clients and as services which diffuse discontent (Wilson, 1993). In so far as there is a public awareness of the control function of

social work there is a consensus that the case work of the predominately female front line workers has "... generally failed to bring people and their situations under sufficient control" (Howe, 1986, p.125). This consensus on the failure of the control tasks of social work reflects the inherent ambiguity which surrounds feminine professionalism (as discussed above).

Therefore, on the one hand, social service professionals work with clients to restore their self-esteem but, on the other hand, they are charged to ensure that their clients do not question the existence of social structures which are contrary to their self-interest. This care/control dynamic inherent in the work of bureau-professionals creates multiple, conflicting purposes and renders rationalization problematic. Greater emphasis on "control" would undermine professionals' own perceptions of their integrity and compromise their role as "... a remainder of the conscience of society." (Heraud, 1973, p.93). Whilst an extension of "care", particularly if this encompassed the empowerment of clients, would threaten the state sponsorship of bureau-professionals. The ambiguity of the care/control dynamic fosters public ambivalence over the function and value of social work.

"... [Social workers] must seek to hold, and to mediate in, the multiplicity of conflict in interpersonal relationships. They deal in shades of grey where the public looks for black and white. And they are bitterly resented for it. They are brokers in lesser evils, frequently faced with the need for choice followed by action whose outcome is unpredictable. (Stevenson, 1994, p.173)."

As "brokers in lesser evils" social workers fail to convince the public that they have a valuable product and, as the consequences of their interventions are unpredictable, they are severely constrained in working towards consistently higher public esteem.

As a caring agency within the public sector the social services also have implicit caring objectives. There are public expectations that the social services will provide good working conditions for their employees—as compared with those that obtain for equivalent activities

in the private sector. However, as they are implicit, these objectives do not attract any resources.

"Demands from public opinion and the legislative as a whole (acting in a non-budgetary role) often mean that government agencies are expected to foster desirable social developments which have little if anything to do with their specific objectives. These requirements.... effectively raise public agencies' internal costs above those of firms carrying out equivalent activities' (Dunleavy, 1991, p.242)."

The ambiguity which surrounds the pursuit of implicit objectives does not serve the social services well. On the one hand the social services attract public opprobrium if they do not meet these objectives but, on the other hand, as these objectives are not officially state-sponsored and resourced, they do not receive any credit for success in fostering desirable public sector working conditions.

Hence the domain of the social services remains unclear and permeated with diffuse and often contradictory purposes. The sites of ambiguity within the social services are, first, in the corporate relationship which is characterized by bureau-professionalism, second, in the feminized nature of social work practice, third, in the processes through which welfare professionals work which are both interventionist and non-directive, and fourth, in the tasks which they perform which are both caring and controlling and which make reference to some implicit objectives. But although ambiguity is a necessary component of social work (as it is presently constructed) such ambiguity creates uncertainty over the intrinsic value of social work activities which, in turn, raises issues about the appropriate levels of resourcing for social work services.

RATIONALIZATION AND RESOURCING

The conventional societal response towards the rationalization of unclear domains is professionalization (Meyer, 1994). But for the reasons

discussed above (around links to state agencies and task ambiguity) in the social services this response has been incomplete. Under these circumstances social work professionalism is vulnerable, it is open to challenge from rival ways of institutionalizing knowledge. In social work, professionalism, as the institutionalization of knowledge in people, faces a formidable challenge from organization, the institutionalization of knowledge in rules (Abbott, 1988, p.325). Incomplete professionalization makes for an uneasy terrain of work. Along several dimensions of professionalism social work is weak: claims for an expert knowledge base are not fully substantiated; public deference towards social workers is low; and, crucially, occupational control of work tasks is mediated by strong state intervention. In these circumstances the rationalization of the social services remains partial, uncertainty and ambiguity are publicly visible and, consequently, public doubts are high concerning social work's productive value.

This situation makes decisions on the necessary resourcing of activities within the social services highly problematic (Meyer, 1994). Without a definitive consensus on what is being produced, how it is being produced, and why it is being produced, resourcing questions are indeterminate across a wide continuum. On the one hand if attention is focused on the counselling aspirations of practitioners within the personal social services to restore their clients' self esteem then, particularly in a society where the claims of religion and political ideology to accomplish "wholeness" are diminishing, high resource inputs are indicated. However, on the other hand, a focus on the socially constructed achievements of the personal social services (where the "new right" attacks on state welfare have combined with long standing public perceptions of social work failure⁶) points to severe resource constraints.

The social services, as other forms of "political organization", also confront a paradox when soliciting resources,

⁶Sheldon, 1986 provides a review of the negative conclusions on social work effectiveness.

"The political organisation which finances its activities from taxes.... will tell their financiers, i.e. the citizens, how badly things are going now or are going to go in the future: it is poor results that demonstrate the need for more money. Since needs are not being satisfied, quality is not high enough and the money is finished, more is obviously needed. (Brunsson, 1994, p. 326)."

The social services must aspire to higher levels of resourcing through claims to poor achievements. They must also, as argued in the previous section, strive to fulfil the implicit objective of providing good public sector working conditions without attracting the requisite resources. These inconsistencies create profound tensions within the social services between "aspirations" and formal "achievements" and augment the high degree of uncertainty over the public worth of the services offered.

These sections on task ambiguity and resourcing uncertainty have sought to establish the nature of the social services context within which boundary-work was active first, in reducing instrumentality by distancing costing from caring and second, in insulating social work practices from decisions on resource allocation in an attempt to curtail further pressure on resource limits. The paper now moves to outline the dynamics of boundary-work in these processes but, first, the research project is described.

THE RESEARCH PROJECT

The empirical research referred to in this paper was conducted in the Scottish regional authorities during 1993/4 and again in 1995/6. Twenty six social services staff were interviewed in posts across the social work hierarchy—from

depute director to care manager. The entire population of the Scottish mainland social service departments were visited (nine in all⁷), only the island authorities were omitted⁸. In 1993/4 the regions were asked to put forward the personnel responsible for care purchasing decisions; these staff most usually comprised a care manager, a contracts officer and a finance officer. In 1995 the research widened its focus to explore further the contracting regime within which costs were being used. Therefore in 1995 contracts managers were the principal staff interviewed but, in some regions, more senior management were also present. In the accounts which follow these personnel are identified as follows: the different regions are given as R1-9; the post of the particular worker is referred to as "C" for a contracts manager, "F" for a finance officer, "S" for a care manager and "DD" for a depute director⁹; and if, at the second stage, the particular person quoted had been present at the first stage a "1" is added to the reference. For example, R6/C/1 indicates a quote from a contracts manager in region 6 who had been present at the first stage interviews.

At the first stage the study used a "real-life construct" or "RLC" (see Lapsley & Llewellyn, 1995 for a detailed explanation of this research method) to explore the decision-making processes inherent in the purchasing function of the social services. The aims of the project at this stage were first, to discover whether costing information was integrated into purchasing decisions in the social services and, second, to establish the nature of the contracting regime within which costing information potentially assumes a heightened significance. In 1993/4 the response of the participants was, in the main, one of disinterest (even distrust) of costing

⁷At the second stage one regional authority declined to participate due to the pressure of work consequent upon the move to unitary (the merging of regions and districts) status.

⁸Other research (Stalker et al, 1994) indicates that in respect of their overall response to government legislation the three island authorities do not differ substantially from the mainland authorities albeit that the Western Isles have declared their intent to fully devolve budgets to individual care managers — although they have not done so yet for technical reasons.

⁹If more than one person was present at the interviews from a particular functional area the participants are numbered. For example, R5/S2 indicates the second care manager in region 5.

information. However, evidence from English social service departments indicated that this situation in Scotland may be transitional. Comparative research conducted in two phases in a sample of 25 local authorities in England indicated a shift in responses to purchasing through "markets" between 1991 and 1994 (Wistow *et al.*, 1994). In 1991 the development of the purchasing function in English social services was "embryonic" and there was a distinct anti-commercialism, by 1994, however, Wistow *et al.* found that 16 directors of social work perceived overall advantages of social care "markets" for purchasing compared with only three who saw overall disadvantages. The directors cited as advantages, first, the identification of opportunities for cost reduction in both public and independent sectors and, second, the capacity to purchase strategically and enhance quality. The main potential disadvantages cited were, first, the possibility of cartels and monopolies and, second, the "exploitation" of staff through the levelling down of terms and conditions of service.

Whilst this research in England was useful as a comparator there are certain aspects of the Scottish situation that are distinctive. First, there is a legislative requirement in England that 85% of money transferred to the local authorities from the Department of Social Security for the purchase of residential care must be spent in the independent (private and voluntary) care sector. This financial pressure does not apply in Scotland. Second, Scotland has had a strong collectivist tradition, hence the political climate in the Scottish local authorities is generally less favourable to the introduction of "quasi-markets" and this circumstance, allied with the prospect of possible devolution, has fostered greater resistance to market-orientated changes in the purchasing function. The government's response to these circumstances has been a more cautious approach to the introduction of change, in particular the pace of change has been slower than in England, mirroring the more gentle introduction of the reforms of the Scottish health service (Lapsley, 1995). This more gradual approach to reform

has allowed greater opportunities for Scottish front line purchasing staff to reflect and learn from the situation in England; resistance strategies can be forged in the light of the experience of the English local authorities. Scottish front line social work professionals stressed their view that England was "different" (see the discussion later in the paper). This was the context in which it was anticipated first, that purchasing care would be a dynamic process in Scotland and, second, that significant differences with the English situation may emerge. In consequence, the social service departments concerned in this study were re-visited in 1995 to explore how contracting for social services was developing. At this second stage semi-structured interviews were conducted which placed the use of costing information within the wider contracting culture of the social services.

The 1990 NHS and Community Care Act set the context which anticipated the enhanced use of costing information within the social services. This act rationalized the previously fragmented responsibilities for community care by transferring functions and funds from both social security and the health service to the social services. Although these transfers in one sense strengthened the role of the social services in community care, at the same time their function as a direct provider of services was intended to decline (Langan & Clarke, 1994). Care "managers" were seen as fundamental in orchestrating this declining provider role as such managers were expected to purchase cost effectively. Contracts managers and finance officers were expected to set the contracting regime in place and to negotiate with provider establishments. The next section gives the accounts of these personnel at the first stage of the research.

USING BOUNDARIES TO DISTANCE COSTING FROM CARING

At the first stage of this study "care" continued to be sealed off from pressures on resourcing but resource pressures were evidenced by organizational actors' heightened awareness of

the "cost" issue. As discussed earlier, the many sites of ambiguity within the social services render demonstrations of the worth of social work practice difficult to establish. Hence there are powerful incentives for social work professionals to set boundaries around "costing" and "caring"—as the explicit calculation of costs raises questions about the worth of the services offered. Through distancing, the caring "parts" of the social services are able to defend their functional autonomy from encroachment (Gouldner, 1959) and caring professionals are free to make decisions which continue to be, in the main, unbounded by consideration of cost. Such a separation also maintains public sector values. Where "costing" and "caring" are kept apart the "organization is seen as being ultimately for people rather than the other way around." (Morgan, 1990, p.23). The disengagement of "costing" and "caring" reduces instrumentality and maintains an organizational identity which "puts people first". Organization in the private sector implies instrumental activities and the accumulation of money or power in the hands of individuals whereas organization in the public sector implies the achievement of collective values as the explicit purpose of the public domain (Stewart & Ranson, 1988). Where the relationship between caring activities and costs becomes more visible, then the stance of "putting people first" becomes less credible; where resource limitations have a clear impact on care decisions, caring becomes more commodified and, in consequence, is less imbued with substantive value. This raises the prospect that, ultimately, "...economic calculation... [could]... emerge as a substitute for value judgement." (Power, 1992, p.479) and practitioners' claims to self-determination through the making of authoritative professionally-informed decisions would be jeopardized.

In the first stage of the study the following quotes illustrate practitioners' views on why (and how) social work practice should be dissociated from costing. When a finance officer was asked how devolved budgeting was progressing in his region he replied,

"The region does not want care placements to become budget driven. Care managers are not constrained by budgets any overspend is underwritten by the region. (R4/F)"

In a similar vein a contracts officer remarked that,

"If care managers were to ring a home and enquire, 'Do you have a place and what's your price?', they'd be shot at dawn... their starting point must be [client] assessment. (R3/C)"

Another contracts officer explained,

"Their [care managers'] process starts with a client decision on community care against residential care and then a home is decided upon. They would then enable the client to go out to the home—not until this point would price come into it. (R1/C)"

Care management in the social services reconstitutes organizational tasks at the external boundary of the organization; the care "manager" is a new boundary role. This care manager is a front line welfare professional charged with assessing client needs and commissioning services to meet those needs. As discussed earlier, under the new contracting regime it has been assumed that care management will encompass a degree of financial responsibility. Devolving budgets to care managers has been instituted so that "... resources flow to the point in the organisation where user needs are assessed." (Langan & Clarke, 1994, p.81). But if care managers take on budgetary responsibilities the crucial distinctions constructed between costs and care are threatened by coupling costing and caring in a unitary task. Rather than operating as dissociated "internally circular structures" (Luhmann, 1989, p.15) costing and caring merge in a publicly visible way at the external organizational boundary. It is, therefore, unsurprising that the care management task has met with some resistance.

Although limited budgets have been devolved for home-based care, at this first stage of the research concomitant financial responsibilities had not been assumed by care managers. When asked by her colleague if she cared if she "*busted the budget*" one care manager responded,

"Not a whit, but, on the other hand, I do care because they [finance] might pull the plug. I'm constantly having to meet that argument [on individualised high cost packages]¹⁰ and over certain levels as a practitioner you have to get agreement. (R5/S)"

Hence the practice of devolving budgets to front line staff does not necessarily result in their taking on the responsibilities to manage any "gaps" between resources and needs. The expectation that front line staff will be forced to perform "emotional labour" (Langan & Clarke, 1994) with clients (when tight budgets do not stretch to accommodate all assessed needs) had been negated by the continuity of a division of labour which shields operational staff from such tensions.

The purchaser/provider split in social care carries an expectation that purchasers (in this study contract managers) will seek out those providers who can deliver "value for money" services, the scrutiny of costing information being a means purchasers can employ in making value for money assessments. However, participants at the first stage maintained an attitude of indifference towards costs (only excepting wage costs). This indifference was sanctioned by adherence to fixed price contracting¹¹. Fixed price contracting renders costing information irrelevant and, indeed, the irrelevance of costs to current organizational practice was one of the responses made in the regions.

"The cost analysis is immaterial to the region, (R4/F)"

commented one finance officer. A contracts manager said,

"Homes are registered to a common standard, they are getting an equivalent fee for an equivalent standard of care. The cost information isn't relevant. (R3/C)"

Another contracts officer stated,

"Costs wouldn't be a determinant. (R1/C)"

The same officer, when asked if homes' capital charges were of any interest, said,

"We'd rather pay for wages. We just pay the price regardless of costs we don't have to look at it.... we are interested in do the staff understand what they are supposed to be doing, are all the staff part-time and, therefore, there are no hand-overs, also will the owner let the manager run it or are they always interfering? (R1/C)"

As the above quote illustrates, the distancing of costs from care seals off caring activities from cost pressures; "care" as the entry point to social work practice then shapes the asking of all questions about that practice (Amariglio *et al.*, 1993).

The strategy of fixed price contracting was strongly defended in the regions and the boundary metaphor of "holding the line" symbolizes this defence.

"We're trying to hold the line on this one, we're very averse to setting individual rates—it would be an administrative nightmare...It may be different in England...Its not in the homes' best interest as inputs can't vary as quickly as people's needs—it just isn't that flexible. (R1/C)"

exemplify the type of favourable comments made on the simplicity of the fixed price system. The simplicity of the system was also cited as a means of avoiding budget "busting", one contracts officer commented that,

"Placing clients choosing different homes charging different prices can lead to budget overspend. (R9/C)"

Fixed price contracting provided a "defensive shield" for operational staff, another contracts officer remarked that,

"The council has a responsibility to fix its rates so that operational staff are not exposed to pressures from pushy managers. (R3/C)"

Fixed price rates softened and civilized the contracting process and prevented any threat of

¹⁰This care manager had a budget of £50 000 of which she was currently spending £20 000 to support one profoundly disabled client in the community.

¹¹Only one of the nine Scottish regional authorities operated a form of differential payment and this was based upon the assessed needs of clients rather than the quality of service provision. In England 18 out of the 25 local authorities sampled were continuing to use fixed rates, but many more English authorities were intending to build in 'flexibility' by allowing market forces to operate (Wistow *et al.*, 1994).

a descent into a Hobbesian "state of nature", where "predatory pricing" could be used as a provider ploy to expand market share and ultimately to exploit market power (Wistow *et al.*, 1994). Where private sector managers had offered prices lower than this fixed rate, such offers were firmly resisted. In one region the contracts officer stated that,

"We have chosen to stick with fixed rates. All the regions' homes charges are equal to or more than this rate except for three homes owned by the same owner. He has set his price at £20 below the going rate in the hope of encouraging the region to make placements there. Our attitude is thank you very much but client choice is paramount. (R1/C)"

Fixed price contracting was, therefore, defended through a number of rationales: the administrative simplicity of a fixed rate; the ease of budgetary calculations (where computational simplicity was thought to avoid budget overspend); and the defensive shield it provides for operational staff against the possibility of "hard-sell" tactics in the private sector. Where the private sector offered financial inducements through price cutting these were resisted by stressing the primacy of client choice.

Social service professionals have a mandate in society to act as "reality-definers" (Esland, 1980*b*). Moreover Weick (1976) suggests that the ambiguity of loosely-coupled systems puts pressure on organizational members to construct "...some kind of social reality they can live with..." (p.13). In their case work with clients this reality-defining role encompasses the setting of individual standards for adequacy and competence but, in addition, the personal service professionals have also "...acquired the right to be consulted on, and to intervene in, a wide range of issues connected with social order, social productivity and organizational efficiency." (Esland, 1980*b*, p.262). Such a mandate ensures that bureau-professionals feel comfortable in defining those circumstances which enable quality of care. At the first stage

of this study participants expressed their beliefs in the relatedness of high costs/high quality. Participants "managed" cost/quality relationships through reality-defining or truth-telling about consequences.

When social service personnel were asked to make choices between residential homes which offered a range of cost/quality relationships they maintained an attitude of disbelief towards those homes which appeared to offer value for money. Such homes were described as exhibiting "contradictions". One finance officer commented that she evaluated costs and quality of care "in tandem" and considered,

"... running costs to be directly related to quality of care and rising annual running costs are indicative of better service provision. (R6/F)"

The attitudes of disbelief towards homes which seemingly offered value for money were buttressed by reality-defining comments on the social services' own high cost residential provision which was described as providing "systems of excellence". One contracts officer remarked,

"High cost and high quality local authority homes provide models of best practice for other homes. (R7/C)"

Another contracts officer stated that,

"Homes which don't pay staff well and don't provide adequate training are likely to provide a lower standard of care. (R9/C)"

Such a response also reveals how one of the implicit roles of the social services-offering the good employment conditions of relatively high wages, permanent jobs and on going training is maintained. Implicit objectives must be met by implicit means. Bureau-professionals do not, therefore, declare their intentions to keep public sector wage levels high but justify the higher running costs which higher wage levels imply by reference to the enhanced quality of care which they believe is positively related to costs.

There are considerable cost differentials between local authority homes¹². Whilst local

¹²In 1990 in Scotland the operating costs of local authority residential homes for elderly homes ranged from £125 to £472 per resident week. These cost differentials were not correlated with measured quality of care nor were they explained by any possible cost-increasing factors such as the extent of the services offered or the nature of the building in which the care was delivered (Bland *et al.*, 1992).

authority homes are ostensibly "cost centres", it is the local authority practice to average the homes charges to generate a single regional fee, thereby introducing cost cross-subsidization between homes. Such practices obfuscate any relations between costs and the care delivered. One contracts officer commented favourably on the straightforward nature of this.

"The present system averages out to the full costs and its simpler all round. (R1/C)"

Thus differentials are obscured by organizational practices—rendering possible cost efficiencies in service delivery invisible. Monetary incentives to contain costs are lacking, moreover, "truth-telling" (or reality-defining) work which portrays costs and quality of care as positively related enhances the reputation of those homes which exhibit "high cost" profiles. High cost homes are anticipated to be also high quality and, therefore, to constitute "systems of excellence".

Costing information was also marginalized by local authority budgetary practices. Costs of placements in the private and voluntary sectors were deducted from managers' budgets but placements in local authority homes were not similarly charged (being funded either from the top-slicing of the community care budget or directly from the departmental budget). Thus local authority placements appeared as "free goods". One care manager remarked that,

"We will admit referrals to any local authority run home as in these cases price does not matter (R9/S)."

Other comments on this were,

"Cost restrictions don't apply to local authority homes...If we place clients in our own homes the costs are shifted on to another budget.(R8/C)"

Yet in one or two regions the cost differentials between the private and local authority sectors¹³ were remarked upon, one contracts officer said candidly,

"We pay the private sector £240 but £330 is the cost of our own homes ... We never keep the costs of our

own homes from the private sector—it's here are the costs of our own homes and then we duck. (R8/C)"

The remoteness of costs from decision-making processes is explained by a consideration of how social workers construct their professional practice. Practitioners in the social services utilize "tacit" or experiential knowledge rather than explicit information. They work in poorly defined situations and,

"Their feelings and perceptions about the situation will be unclear, as the information they are identifying is ambiguous and confusing. Through discussion with other social workers and each individual worker's "gut feel" a picture will slowly emerge indicating what action to take next... it is not easy to change information from being tacit to explicit, as tacit information is by its very nature, confusing and ambiguous. (Kakabadse, 1982, p.132)."

Social workers engage in a great deal of face to face group linguistic work (Weick, 1976, quoting Mitroff & Kilman, 1975) in order to identify their clients' concerns and problems. As one care manager expressed it,

"Our starting point is always the individual's circumstances. (R5/S2)"

From this "starting point" social workers construct case histories of

"About 15 pages of detailed information in order to gain a full appreciation of the clients' needs.(R9/S)"

The sites of ambiguity in the social services render the consequences of social work practice difficult to predict. In these circumstances the "...intentions of the action serve as surrogates for the consequences." (Weick, 1976, quoting Salancik, 1975; emphasis in the original). Social workers construct detailed case assessments in order to inform their intentions to serve clients' needs. However public sector accounting does not attach costs to intentions but only to consequences. Where good intentions to serve clients' needs do not translate into good outcomes social workers are likely to resist accounting's attribution of the consequences of their actions in financial terms.

¹³Across all regions in 1990, the average cost per resident week for local authority homes was £216, for homes run by voluntary agencies it was £164, and for private sector homes it was £145 (Bland *et al.*, 1992).

Therefore working with experiential or tacit information renders the consequences of practice ambiguous but such information has, traditionally, been the "trusted" knowledge base of social work. Within this scenario costing information will appear disconnected (from good intentions) and decontextualized (from practice). Accounting information is crucial for activities which are conducted "at a distance". But, "When the actor is situated in the context he or she wishes to influence, then decontextualized representations assume much less significance." (Robson, 1992, p.701). Social work is the epitome of a practice which is contextualized. Hence the perceived significance and relevance of highly structured, representational information, such as costs, to this practice is likely to be low. Costs, within the realm of social work, remain "data". They are not converted into "information" (Wildavsky, 1978) as they are not aligned with the tacit, ambiguous knowledge base of the welfare professional. This non-alignment is illustrated by the comment of one contracts officer on how residential care establishments in financial difficulties were identified,

"Our financial people check the accounts periodically—not that that tells you much about viability... usually, though, we will have a feeling that the home is in financial difficulties. (R1/C)"

Thus at the first stage of the research the "feeling" of the experienced professional was much more to be relied upon than dubious representational "accounts"—these "didn't tell you much".

DOING BOUNDARY-WORK TO ALIGN COSTING WITH CARING

The fundamental assumption underlying the idea of boundary-work is that "organization" should be seen as a "process verb" (Parker, 1992, p.6). Organizational boundaries are "...scenes of potential instability" (Power, 1990, p.117) and the process of organizing happens through inclusion/exclusion at these boundaries (Llewellyn, 1994). The maintenance of these

boundaries substantiates claims to difference/similarity and these claims are intrinsic to ongoing organizational processes (Power, 1995a, p.31). In the social services the exclusion of costs from caring activities has disengaged these domains and prevented the "inconsistencies" (Brunsson, 1989) and differences between "costing" and "caring" becoming problematic.

The creation of these differences, through the construction of boundaries, can be termed a "...difference technique" (Luhmann, 1989, p.18). Boundaries build distinctions; they enable perceptions of "this" rather than "that". It is for these reasons that fundamental change in the social services is only possible if boundaries are re-drawn with consequent disruption and reconstitution of difference/similarity distinctions. Costing and caring have been perceived as possessing "significant differences" (Cooper, 1990) by social workers. Moreover, any costing of caring raises questions about its value and, in the social services, where public perceptions of the worth of the services offered are not high (see the earlier discussion), explicit "costing" will be seen as threatening to the survival of core social work practices. Boundary-work which will allow for some integration of costing in a social work setting will bring out the possible similarities between the domains of costing and caring, by highlighting any cross-domain categories of analysis (Klein, 1993) or common activities (Weick, 1976). However, this identification of areas of "similarity" between costing and caring must be accompanied by some perceptions of how costing may possibly support, rather than threaten, social work practice. Without this mutual support, the survival of valued caring activities is cast in doubt. In this way costing becomes aligned with, rather than being defined in opposition to, caring.

This section makes reference to the second stage of the study (conducted in 1995). The first two quotes illustrate how contracts managers in the social services now think that contracting may assist in substantiating clients' rights. "Rights" is cross-domain activity which

highlights some similarity between care and the contracting regime in which costs are embedded.

"People do see contracting differently in a more positive light—well I think "positive" is the right word, they are seen as a means of establishing rights and responsibilities, they spell out roles... a couple of years ago contracts were thought of as a waste of time—as just more bureaucracy. Care managers do come to us now if they're unhappy about some aspect of the client's care they say "Is there anything in the contract about this?" (R7/C)"

"Care managers are interested in rights issues, even if the client is self-funding, they will offer them the contract anyway. (R3/C/1)"

Once the contracting regime was established, budgets appeared as a "natural" progression.

"There was more resentment of contracting than of budgets—contracting came first.(R6/C)"

Some felt that budgeting could free up more money for caring.

"It's conceivable that the system will produce more money to spend. The all beating all bleeding hearts approach is gone....It's a damn good thing in my view. If we are more cost conscious we should be able to serve more clients, it's not damaging in any way. It doesn't affect the client's dignity—the client isn't compromised in any way. (R6/C/1)"

This quote illustrates the belief that even if costs permeate the caring domain core values (e.g. clients' dignity) are not undermined and, hence, the care domain is not threatened with fragmentation (Messer-Davidow *et al.*, 1993).

Having a budget for a particular client group can enhance the profile of that group. Thus costs can highlight the interests of "cinderella" groups—if such groups are seen to attract resources. Hence it can be argued that costing can curtail the ambiguity of social work practice by countering the tendency of practice to be driven by public sensitivities rather than professional decisions which strive for equity between different client groups.

"It's changed the relative weight of the different client groups. Having a budget for community care has begun to shift the focus away from families and children—they were the elite group—well maybe that's a bit strong but there is such public sensitivity about the response to child welfare and there's the risk element. (R5/C)"

Although front line professional workers operate at the periphery of the organization their concerns have centred on the needs of the individual client rather than on any aggregate societal benefits. Professionals have never focused on issues of "... total provision or costs of service, total quality of results and the like—even though these have long been measurable phenomena and matters for occasional public outcry." (Abbott, 1983, p.860). Boundary-work to align costing and caring has begun to shift the focus of bureau-professionals from the individual client to aggregate societal need. Where resourcing is constrained, such a shift in focus implies prioritization between different clients.

"If a social worker was continually over spending to the detriment of other social workers and other clients—it wouldn't go on for very long. (R6/C/1)"

"I think that they [social workers] struggle with the notion of cost—it does conflict with the whole social work ethos and training. I've always thought that it was funny to talk about social work teams—because really it's a very individual thing. They fight for what is best for their clients and blow other social workers and blow their clients—they've always competed with other social workers for resources but now it's changing because they are beginning to have to prioritize between their own clients—making choices about if Mrs Jones gets X Mrs Y won't. But different social workers see it differently. (R7/C)"

These views indicate the beginnings of some alignment between costs and care. Costing practices are seen to be potentially supportive (or at any rate not destructive) of certain key social work values such as rights, dignity and equity between client groups. Also, cost consciousness is thought to have a potential for releasing extra resources.

"FORMS OF RECEPTIVITY" ARE ACCOMMODATED BY SHIFTING BOUNDARIES

As boundaries are blurred (Klein, 1993) between caring and costing—if costing is shown as aligned with social work values—simultaneously social work is being reconstituted in ways which highlight the applicability of

cost accounting within its boundaries. Power (1994), p.308) has referred to this process as the active construction of "forms of receptivity".

"I call it fine tuning.....the department has had to look again at what they are doing. There's more effective financial control. There are cries that we didn't join social work to fill in forms and how they have to put down everything that the system wants—it's the disorganised or chaotic individual who is the most upset. It's re-examination not redefinition. Of course some individuals will say that they've been professionally compromised but they're wrong and it's not logical. (RG/C/1)"

"I think we are more organized and more responsible and accountable [through contracting] although we were dragged kicking and screaming into it....I think new care managers see contracting as important, the "social worker know best" model is going. At the corporate level it's seen as important and it can inform elected members—it's a useful tool to keep standards up. (R3/C)"

The above quote illustrates some aspects of the structural reconstitution of social work, particularly highlighting the significance of "new" care managers in challenging "old" social work values. However, although these processes of alignment and reconstitution have produced some engagement between costing and caring as boundaries are re-drawn, the values of accountability and responsibility can still sit in stark contrast to the inherent indecision and ambiguity of social work practice. Where "real" social work (the professional counselling task) has to defend itself against the encroachment of managerialism it can find itself exposed as lacking in substance and as being devoid of objectives.

"Social workers will feel that it's changed—certainly their work has become more visible, more accountable, more open to scrutiny. There were some sloppy practices—although some of them will say that they feel like "sausage machines" and they spend all their time filling in forms. They say to me that there's no time to do "real social work" but when I ask what that is they find it difficult to answer. I suspect that often it was having a cup of tea with the client to no particular end. (R7/C)"

The insubstantial nature of "real" social work—reflecting its "soft" epistemological structure (Klein, 1993) renders it permeable to discourses of financial control. The above quote (along with the two preceding ones) also illustrates the changing nature of social relations in the social services. Whereas previously financial decision-making was "embedded" (Granovet-Granovetter, 1985, p.487) in consensual social relations which "put people first", now contracts managers express scepticism about the robustness of professional social work. These active processes of alignment and reconstitution underline that social services departments are "enacted" (Morgan, 1986, 1990) domains. The consensual views (between care managers, contracts managers and finance staff) on protecting front line staff from financial pressures which were apparent at the first stage of the research had broken down two years later and differential views on the appropriate reconstitution of social work practice had emerged. These changes have fostered a sense of confusion in some front-line workers which has been manifested in "... an overwhelmingly defensive set of concerns about how to hold on to cherished "professional values", identities and practices in the emergent new regime." (Lan-Langan & Clarke, 1994, p.78).

The key structural constraints driving boundary-work to create "forms of receptivity" in the social services are, first, the creation of care managers (discussed in previous sections), second, the transfer of the budget for residential care from social security to social work departments, third, the financial "squeeze" on the public sector as a whole, and, fourth, the turnover of social work personnel as new people come to occupy key positions¹⁴. Contracts managers commented as follows on the transfer of the budget and on the impact of financial constraints.

"The transfer of cash to the social services was the big thing so the responsibility lies here. When social security paid [for care] social workers just referred

¹⁴At the second stage of this research 4 of the 9 contracts managers in post two years earlier had either transferred within the social services, left to take up positions in health care, or left public sector service completely.

clients straight into residential homes—they didn't have to think about it. (R2/DD)"

"The financial squeeze and the contract culture have together driven change. (R6/C/1)"

"I think that we have got to become more aware of the costs of the services we provide. The financial constraints on the whole of local government are such that the old ways of doing things can't be perpetuated. We've got to have forms of performance management. (R8/C)"

The practice, which was apparent at the first stage of the research, of shielding front line workers from the effects of financial constraints by underwriting budget deficits had, two years later, given way to "educating" front line staff on their budgetary responsibilities.

"People do feel constrained—there's only so much money—line managers told social workers that the transfer money wasn't enough and that it would get worse. The money can only be spread so far. (R9/C)"

"There's a heightened sense of limited resources—that's the result of cuts—they [front line workers] know there's no longer a bottomless purse. (R6/C/1)"

"The cost issue is more blunt—you can't ignore it. (R7/C)"

A recognition that change involves boundary reconstitution explains why the deployment of new and different management personnel is fundamental to the accomplishment of change in the social services—as new managers break down the cohesiveness of the boundaries of expertise of professional groups (Gieryn, 1983).

"Ms B (new Head of commissioning and purchasing) has brought in a commercialism—that's a plus. It's just experience really, giving the organisation time to change the culture and, well, the new director will push a lot harder. (R6/C/1)"

"I think that background affects how financially aware care managers are. Care managers can be either nursing, OT [occupational therapy] or social work in background. I think that the ones from nursing and OT are more financially aware than those from social work. Is that a terrible thing to say? (R4/F)"

Accountingization, as a problem-solving discourse, also increases the interdependence of functional areas of expertise rendering boundaries more permeable (Klein, 1993). At the first stage of this research participants defined

caring work as solely focused on the client's problems—that these problems were frequently unsolvable rendered caring work highly linguistic and hence, the social services conformed to Brunsson's (Brunsson, 1989, 1994, 1996) idea of the "talk" organization. But the pull of problem-solving creates linkages between the previously "internally circular structures" (Luhmann, 1989, p.15) of social work practice and finance.

"Relationships work well [with finance], we've certainly had a lot more to do with them. They're no longer faceless—we can put names to faces now. (R9/C)"

Once the boundaries between finance and social work practice are made more permeable, finance can inform social workers on "what's do-able" and a "talk" organization becomes more of an "action" organization (Brunsson, 1989, 1994, 1996).

"Finance Office are a powerful interest group in any local government service. There's been a deliberate management strategy to make it work—we've implemented commitment accounting systems—before people only knew what they had spent, now they know what's left in the budget so they know what's do-able. (R5/C)"

Commitment accounting (the on-going feedback of financial information on "what's left" in the budget) now provides a realm of rationality within the social services where actions can be appraised as responsible or irresponsible, and, hence, where disputes can be adjudicated (Miller, 1992, 1994). The coupling of finance with caring through commitment accounting also dissolves the temporal boundaries which had previously existed between financial control measures and professional social work action.

"The time lag, forwards and backwards, in budgets and accounting reports, makes it difficult to couple finance and activities. Costs concern either plans about future activities (budgets), which are contemplated but not yet immediately at hand, or the outcome (accounting) reports on the financial effects of activities that have already been carried out some time ago. The moment of truth for the professional is, however, the application of that person's specific competence to a unique problem, at the present time. (Jonsson & Solli, 1993, p.305)."

Now social work decisions are conjoined with an immediate awareness of financial constraints and "moments of truth" (see the above quote) occur within the context of commitment accounting.

The transfer of the budget to social work departments put an additional onus of responsibility on social work management to deploy resources in a more cost-effective way and created a potential conflict of interest between senior social work management and front line professionals. Reconstituting the boundaries of social work practice to include costing also raises questions about the appropriateness of a professional social work training which excludes reference to costing issues.

"It depends on the level in the organization. We've still got care managers with quaint old fashioned ideas who say 'I've got my principles and I'm going to give my client the care they need regardless of cost'. But awareness is increasing, social work management have been acutely aware of cost factors for the last ten years but costs are not part of the cultural training of a service deliver. Costs just aren't in the training—they don't address it at all, it's CCETSW [social work's professional training body] who put the ideological bones into social work training—that's where the fanatics for all the long lost battles are. (R2/DD)"

The conflicts between costing and caring are less apparent away from the front line of service delivery because social care management are not in "face to face" situations with clients and, therefore, do not confront the "emotional labour" (Langan & Clarke, 1994) engendered if tight budgets do not stretch to meet particular clients' needs. Front-line workers depend on establishing intimacy with clients in order to conduct their professional practice. The intrusion of "costs" into the professional/client relationship potentially disrupts the trust which is necessary for professional counselling tasks, whereas social work management occurs in a context which is disengaged from intimate contact with clients.

"Well the nearer the centre you are the less you talk about people, well not named clients anyway. When you don't see the people you're more immersed in the finances. (R6/C/1)"

However this does not imply that the change process in the social services is totally top-down, some contracts managers see change as "patchy", flowing from previously suppressed "pockets of entrepreneurship" throughout the organizational hierarchy.

"I wouldn't describe it like that—of permeating the organization from the top down—I would describe it as patchy. It's about political preference but it's also about people's individual preferences. Some people enjoy a sense of comprehensive responsibility, some people enjoy negotiation—they get a gleam in their eye—they like the entrepreneurial combative thing. (R5/C)"

Although this does not deny that the reaction to some dissolution of the boundaries between costing and caring is varied and some care "managers" still wish to disregard costs when they make decisions on care for their clients.

"At the beginning some people didn't think they had a budget or that's what they said anyway. Also they didn't think about the on-going commitment—the rolling commitment of the region. Others took the choice directive too literally—it's not just what the client needs but what it will cost... Some people find it liberating to negotiate on costs and some people have put together some very innovative services. But some people still think that their job is to ensure people receive care without regard to cost. (R8/C)"

Change has not addressed the "paradox" (Brunsson, 1994) of soliciting for resources in the social services where overspending signals unmet need.

"I know some team managers who are quite happy if they can overspend, they think that it demonstrates the need and gives the right messages. (R5/C)"

But although overspending can give the "right" messages, by the second stage of the research commitment accounting curtails budget deficits and, hence, hinders the practice of soliciting for resources on the basis of financial signalling of unmet need. Moreover, at the second stage, the "reality-defining" role of bureau-professionals which had portrayed high cost-high quality local authority homes as "systems of excellence" was less in evidence. Instead there was a felt need to justify the high cost of local authority homes not through

"truths" about links with quality but in cost terms. Thus truth-telling about high cost/high quality had been superseded by notions that "high cost" must be defended through reference to, for example, higher overhead costs.

"When we justify our costs to the private sector we say they are higher because of allocated central administrative costs but I don't really think that it's true, the director's salary for instance—that wouldn't be allocated would it? But that's what we say to them. (R7/C)"

There was also an increased focus on the costs of service provision in the independent sector—where two years earlier any cost analysis was thought "immaterial to the region".

"We would look at assessing 'reasonable costs', for instance, if we were reviewing the accounts of voluntary organisation and we saw a central management charge of 25% we would quibble but we recognise that there's got to be a reasonable rate of return in the independents. (R3/C/1)"

Moreover there was pressure on the "implicit" (Dunleavy, 1991) objectives of the public sector as "good" employers to provide better wages and conditions of employment than are obtained for equivalent activities in the private sector.

"There are already changes you could say we were very liberal employers. If someone was off ill we'd pay a substitute—if they were off we would pay someone else—it did end up occasionally we'd be paying three lots of wages. Then there's additional payments—sleeping over—basically we've rationalised—streamlined staff structures and enhancements—that's the technical name for them. (R6/C/1)"

Despite boundary-work which has allowed some engagement between costing and caring, first, through processes of alignment to reveal some congruities (where costs support social work values) and, second, through the reconstitution of social work practice in ways which allow for the application of cost accounting, some boundaries have been maintained.

All regions (except the one which "broke ranks" two years ago) continue to "hold the line", as one contracts officer described it (see the quote on p. 34), on fixed price contracting. The metaphor of "holding the line" aptly

captured how this boundary-work contains risk by continuing to delineate "...the acceptable domain of activity..." (Simons, 1994, p.39) for the social services. In this way market behaviour is avoided and the "defensive shield" fixed price contracting provides for front line workers is upheld—protecting them from any upward pressure on prices which social work managers anticipate as emanating from the private sector. The external boundaries of any organization are set at the limits of the domain within which organizational members judge that they are able to exercise control (Pfeffer & Salancik, 1978). If this theory is applied to the social services then organizational members clearly fear a loss of control to the independent sector through contracting. Boundaries both contain risks and constrain opportunities; they are, simultaneously, constraints and advantages and, therefore, they constitute sites of struggle (Cooper, 1992). In this struggle, contracts managers perceive that significant boundaries have been breached. One contracts manager summed up prevailing attitudes consequent upon boundary-work.

"There's a softening of attitudes [in the social services] it's as if we have been let off a leash, we feel that now we're able to do business. (R3/C/1)"

Yet although there is a sense of liberation from old boundary constraints, there is also a recognition that the indeterminacy of the resourcing question—flowing from the sites of ambiguity in the social services—is being resolved by limiting the aspirations of practitioners to deliver "wholeness" to their clients.

"We may have to distinguish between quality of life and care needs—we may have to accept that we may not be able to commit money to meet certain quality of life things. (R8/C)"

DISCUSSION AND CONCLUDING COMMENTS

This paper is microprocessual in its focus. It has not offered discussion of the historical origins of the processes observed within the social

services nor has it explored the political intentions inherent in the rationalization of the public sector. Instead the paper has focused on some of the consequences of this rationalization in particular settings. This approach does not ignore the impact of new structures (the transfer of the budget from social security to social work; the financial constraints; and the contracting regime) on social work practice but it does imply that the consequences of the introduction of these structures on organizational processes cannot be predetermined by reference to overarching, totalizing, explanatory theories. If organizational processes cannot be reduced to essential inner principles then empirical work is necessary to capture the complex and contingent conditions in and through which organizational action occurs. This implies a close relationship between empirical work and theory. Boundary-work is a way of theorizing process which captures how organizational change is negotiated through people.

At the first stage of this study "costs" (and consequently public sector accounting) were subordinated to "caring", and action to defend "caring" from the encroachment of costs was in evidence. By the second stage, cross-organizational collective action was negated by a diversity in approach to the realignment of "costing" and "caring". Some participants clearly sought to align the public sector accounting categories of "efficiency", "effectiveness" and "accountability" with some of the core valued categories of caring—"equity", "rights" and "dignity". But in these processes of alignment social workers lack clear professional "markers" on where it should "stop" on costs as they lack clear professional control of their domain of work. As discussed earlier, social work professionalism is incomplete along several dimensions. First, there is strong state influence over work tasks—as the state mediates in the relationship between the practitioner and the client. Second, feminized nurturant skills do not enjoy legitimation as claims to professional competences. Third, successful outcomes are difficult to demonstrate with a client base composed of disadvan-

tagged people. Fourth, the public is ambivalent concerning both the value and the function of social work in dealing with the problems of social living. Incomplete professionalization renders social work permeable to the institutionalization of knowledge in accounting technologies. Sites of ambiguity in social work practice become pockets of receptivity for public sector accounting and, consequently, processes of alignment are outstripped by processes of reconstitution.

Medical work, in contrast, possesses a strong epistemological structure (Klein, 1993) and, in the UK, has resisted fragmentation through the intrusion of public sector accounting. Clinicians have been successful in retaining the power to define the true nature of their domain of activity—the problems of illness (Armstrong, 1993). The interpretation of clinical expertise being fixed in the public mind as the outcome of a technical process mediated through judgement (Power, 1995b). Therefore clinical expertise is the publicly accepted discriminator between effective and non-effective medical treatments. In medicine, costs only intrude into decisions on health care treatments where there is no medically indicated consensus on "success"; that this situation is rare is indicated by the very low incidence of the use of costs in clinical audit—Kerrison *et al.* (1993) reported only 3% of medical audits making reference to any cost data. Hence, in medicine, "costs" can still be excluded from the clearly bounded domains of accepted clinical expertise. Moreover, professional practice is not threatened by the potentiality for "costs" to disrupt the intimacy of the doctor-patient relationship. In contrast, in social work, professional judgement operates in socially constructed "grey" areas and the active co-operation of the client is essential for successful therapeutic outcomes. Hence where a consideration of costs disrupts an organizational identity of "putting people first" the front line professional practice of social work in face-to-face encounters with clients is increasingly jeopardized.

The boundary-work which had dissociated costing from caring had created gaps which

served as resources for discretionary, professional action (Power, 1994) or for what Dunleavy (1991) has referred to as "bureau-shaping strategies". This discretionary or bureau-shaping action had manifested itself in activities apparent at the first stage of this research: reality-defining about high cost/high quality; the maintenance of good working conditions in the public sector; and reliance on tacit, experiential knowledge for decision-making processes. As discretionary "gaps" are squeezed through processes of alignment and reconstitution, professionalized discretionary action in the social services is curtailed: truth-telling about high cost/high quality is replaced by justifications of high cost in terms of inputs; the implicit objective of maintaining good public sector working conditions is deflected by the rationalization of staff structures and enhancements; and commitment accounting marginalizes tacit knowledge as a basis for decisions about "what's do-able". By the second stage of the research differential responses to the the curtailment of professional discretion and the reconstitution of caring had emerged within the social services. Contracts managers and more senior management were much more sanguine about "costs" beginning to direct social work. This analysis indicates a divergence of approach between the management core and the front-line professional periphery of the organization and is suggestive of organizational fragmentation as managers become cut-off from the client-centred concerns of practitioners (Pahl, 1994, p.199). However, some of the front line care managers in this study actively embraced a more entrepreneurial approach; this may imply that the tasks of advocacy (on behalf of the client) and resource management can be combined without undue tensions.

The talk that professional social work's therapy-orientated interventions have failed and, as a consequence, government agencies and administrators have "taken over" social work in a search for efficiency in service-delivery (Sibeon, 1990, p.97) suggests that the social services face threats at the external boundary of their organization. Moreover, as argued earlier,

social workers fear increased external competition from the independent sector in their role as service providers. Such threats, allied with severe external resource constraints, imply a shift in boundary-work activity—from the maintenance of internal boundaries of expertise to the shoring up of the organization's external boundary of control. This research shows how social workers have ceded the professional discretion conferred through the maintenance of internal boundaries of expertise between costing and caring in order to address the instabilities building up on the external organizational/societal boundary. Forging linkages between costing and caring attempts to restore legitimacy in the eyes of funding agencies and may keep government agencies from even more interventionist measures in professional practice. So far as the challenge from the independent sector is concerned fixed price contracting continues to ensure that external providers cannot exploit any competitive price advantages and the social services' domain of control over service delivery is upheld. But attempts to restore a stable domain of control for the social services have not eased resourcing constraints and, consequently, there is evidence of a downgrading of service delivery aspirations as contracts managers speak of being unable to commit money to fund quality of life for clients.

Professional control, founded on expertise and judgement, sets out particular jurisdictions (Abbott, 1988) but managerialist accounting control, reliant upon rules and calculative techniques, "... becomes incapable of defining the 'limits of its own applicability'." (Power, quoting Gorz, 1992, p.480). If managerialist accounting controls are not self-limiting it falls to professionals to define their boundaries. But professional control of social work is weak and, moreover, social work practice is already socially problematized. Hence public sector accounting presents as a resolution (in Callon's 1986 sense) to the sites of ambiguity in social work by providing a disciplinary framework for containing discretionary professional action. This disciplinary framework is achieved by

establishing conduits (Clegg, 1989, p.205) or obligatory passage points (Callon, 1986) through which organizational discourses must flow. Commitment accounting constitutes such a conduit; and caring discourses pass through it on terms which privilege costing. As "costing" and "caring" (the respective entry points to the domains of public sector accounting and social work practice) are reconstituted and costing conduits are established through which caring discourses must pass, bureau-professionals are still struggling with the boundary-work which would define the limits of the applicability of costing within the social services.

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Pushing budgets down the line: ascribing financial responsibility in the UK social services

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Introduction

This paper is concerned with delegated budgets in the social services. The central intent of the paper is to, first, locate the devolution process as a responsibility allocator (Brunsson, 1989, pp. 116ff; Brunsson, 1990) and then, to trace how attributions of responsibility in the social services are dissipated through social and organizational processes. The concept of responsibility and, in particular, the processes through which responsibilities are ascribed have been relatively neglected in the academic accounting literature (but, see Brunsson (1990), who links organizational decision making with the assignment of responsibilities). Attention has been focused on exploring accountability (Humphrey *et al.*, 1993; Roberts, 1991; Sinclair 1995; Townley, 1996, among many others). This is curious as accountabilities cannot be invoked unless responsibilities have already been assigned; one can only call for an account (an explanation of what has happened) from a responsible agent or agency. Responsibility ascription defines who (or what) is responsible (Hart, 1951; Shaver, 1975). Ascription is necessary as "...responsibility is born outside of the responsible person. It comes on him because he finds himself in circumstances that engender it" (Fauconnet, 1920, p. 91). Once responsibilities have been ascribed, accountabilities can be constructed. It is in this sense that responsibility is an *a priori* to accountability and this leads Hoskin (1996) to argue that, once this *a priori* is in place, accountabilities extend assigned responsibilities.

Previous to the public sector reforms the social services had constituted a strong hierarchy with numerous prescriptive rules; these rules had enabled collective action (Wildavsky, 1986, p. 23). Strong hierarchies (where, although actors vary, their decisions do not) cause attributions of responsibility to be made to the organization, as it is supposed that organization rules have accounted for the decisions (Shaver, 1975, p. 127). In contrast to this situation, delegation aims to create budget-holders with individualized autonomy, calculating selves (Miller, 1992) who transact freely and who allow for the

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unequivocal location of responsibility and blame. For a person is a readily identifiable locus for the application of sanctions whereas it is much more difficult to take restitution from an organization.

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The attribution of responsibility and the creation of difference go hand in hand. The delegation of budgets is a form of disciplinary power which allocates responsibility, the individualizing effects of this are to internally divide and partition the organization, these divisions and partitions then act so as to impede any coalitions of collective action in pursuit of common goals (Roberts, 1991). But the delegation endeavour ignores the dialectic of social relations (Ollman, 1978) which always contains the potentiality for renewal. The nature of social relations in the social services is such that attempts to create what Miller (1992) has termed the triptych of individualization-responsibilization-calculation will tend to be displaced by the formation of local, informal socializing forms of accountability or responsibility (Roberts, 1991). As accounting in general, and devolved budgets in particular, do not have strong behavioural controls (Armstrong, 1994), focusing instead on making agents responsible for the economic consequences of their actions, the delegation endeavour is not constructed to cope well with those social processes which tend to circumvent its ascriptions. Where social processes are embedded in institutional arrangements that define the logic of the situation (Popper, 1945), individuals see particular events in terms of knowledge derived from their traditions. It is even more difficult for accounting controls to displace these institutionalized responses.

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The paper illustrates the formation of socialized loci of responsibility by reference to the internal relations (within the social services) between client services managers, team managers and front line care workers. The allocation of responsibility to individuals is seen to be mediated, first, by social processes which delimit the appropriate characteristics of responsible people (or individuals who can make choices) and, second, by the retention of prescriptive organizational rules that define the logic of the situation and which, therefore, negate the creation of autonomous calculating selves.

The paper is structured as follows: first, the paper explores the concept of responsibility; second, the research method is described along with an outline of the "why" and "how" of the delegation process in the social services; third, reference is made to the research sites (and organizational events are theorized through notions of individual and socialized responsibilities); fourth, the paper concludes with a discussion of the complexities of using budgetary mechanisms to attribute responsibility in the social services context.

The concept of responsibility

The idea of a responsible agent arises with the modern division of labour and differentiation of function. Evaluation of whether or not agents are responsible and about whether or not they are acting responsibly follows from role specialization, for any role can be filled well or badly and any traditional role behaviour can be continued with or broken away from (MacIntyre, 1967, p. 84).

In pre-modern societies the concept of responsibility remained marginal as role specialization was not sufficiently developed to prompt reflection on its implications for morality.

Once responsibility has been assigned it may be said to have two faces: "...responsibility is 'to' others 'for' certain activities" (Spann, 1978, p. 493 quoted in Thynne and Goldring, 1981, p. 197). The latter involves "having assigned tasks" while the former implies "answerability" or responsiveness to others. Both in the carrying out of assigned tasks and in terms of responsiveness to others, agents are expected to act responsibly – in the sense of appropriately (or in accordance with an awareness of circumstances and moral codes).

The corollary of responsibility is authority. The concept of authority is derived from the old idea of an "auctor" or one who produces, invents or causes in the sphere of opinion, counsel or command (Benn and Peters, 1959, p. 18). Where authority resides in an individual this person is designated as the originator of decisions and, therefore, can be held responsible for the consequences of that decision making. Where responsibility and authority are conjoined in an agent, this person becomes a "producer of effects" (Shaver, 1975, p. 95). Anyone who produces effects is a responsible, causal agent.

Responsibilities can be assigned not only to individuals but also to collective agencies. Shared or collective responsibility can be considered to be ethically more compelling than individualized responsibility. Responsible individuals must be aware of the moral codes of their society but they need not, necessarily, adhere to them. In contrast, shared responsibility implies individuals participating in a normative order and being bound by its principles (see Rousseau (1913), for an early exposition of this thinking). Moreover, where individual organizational roles contribute towards the common good, shared responsibility for activities carries morality in the same way as does collective responsibility to others.

Where the collectivity does not share basic moral values or where it seeks to promote the wider public interest (but that public interest presents a number of conflicting demands) then prescriptions for the common good cannot emerge and collective responsibility will become problematic. If the public interest cannot be made "conceptually and politically specific" (Jos, 1990, p. 229) it cannot embody an unambiguous set of aspirations for public policy. Liberal theories of responsibility reject communal prescriptions of the common good on the grounds that internal criticism cannot distinguish between good and bad communal practices (Badhwar, 1996). Given these perceptions, either the liberal ideal of the autonomous responsible individual imbued with moral sensitivity, understanding and courage will hold sway (Jos, 1990) or collective responsibility will be seen to lie in the processual rules which define the logic of the situation. If a sovereign person emerges this person will be seen to make choices which are not bound by prescriptive rules; as these choices will reflect judgement, the decision maker can be considered the cause of subsequent events and, therefore, can be praised or can be blamed for them. If

responsibilities are seen to be embedded in organizational rules then the organization, as an entity, will be held responsible. Pushing budgets down the line

However, there remain circumstances where responsibilities cannot be assigned either to persons or to collectivities. Where causality (or the production of effects) cannot be established and where it is unclear as to whether any moral agent (or agency) is at work responsibility will be assigned to the "situation" (Shaver, 1975, p. 98). Here the "situation" is conceptualized as being a juxtaposition of chance events, as being transitory in nature, or as being composed of elements where too little is known about their interconnections, their causes and their possible solutions for responsibilities to be ascribed (Brunsson, 1989, p. 146). But where there are no ascriptions of responsibility to people (or entities) events appear to be random or uncontrollable, giving rise to anxiety and denying beliefs in a just world (Shaver, 1975, p. 106). As attributions of responsibility to "situations" do not make events more meaningful they are avoided if at all possible.

In the empirical material which follows the next section, shifting attributions are seen as responsibility for devolved budgets passes between individuals, collectivities and situations. The links between responsibility and authority that are necessary for the production of responsible causal agents are not demonstrated. Moreover, there is ambiguity over whether responsibility for meeting the basic moral values implicit in the social work culture can be aligned with the new financial responsibilities of devolved budget holders. All of these difficulties problematize the delegation of budgets in social work departments.

The research method and the delegation process

The research aims are twofold, first, to discover the organizational and social issues that negotiate the level of delegation in the social services and, second, to determine (once ascriptions of responsibility have been made) if these ascriptions remain individualized or whether they are dissipated – becoming socialized or collectivized in nature. In order to answer the question about the level of delegation eight regional social service departments were visited and the person responsible for commissioning and purchasing was interviewed (using a semi-structured format). At this first stage of the research, ten personnel were interviewed in all (as two regions put forward two people for interview under the remit of commissioning and purchasing). In order to ascertain how far budgetary responsibilities remain individualized, four areas of one particular social services department[1] were identified and practice team managers (the lowest level of delegation found) were interviewed in a case study on issues around their sense of budgetary responsibility. At this second stage of the research, five staff in all were interviewed (as in one authority a person from the team manager's group was present). In the sections that follow, participants interviewed at the first stage are anonymized, but their region of employ is numbered from 1 to 8 and their occupation is distinguished as follows: C = contracts manager; DD = deputy director. At the second stage, all participants were employed in region 5. They were all (excepting one) practice

team managers (PTMs) but they were assigned to different areas – accordingly they are designated as from A1-4.

The processes of ascribing financial responsibility for purchasing to social service departments began with the transfer of the budget (for clients requiring residential care) from social security. Prior to this transfer, the responsibility for funding residential care lay with social security but the decisions on entry to this care (for publicly funded clients) were made by the social services. This situation gave rise to a “perverse incentive” (Wagner, 1988) for social services personnel to make placements in residential care rather than providing services to support them at home because the cost of community care would be met by the social services whereas the cost of residential care would be passed on to social security. The budget for residential care usually lies at client services manager level (see Figure 1) but in some authorities practice team managers work to nominal budgets for residential care.

The 1991 NHS and Community Care Act provided resource to the social services to enable care in the community. The budget for this was split between purchaser and provider functions. The purchasing budget is termed the “care at home”[2] budget whereas the provider budget is the “home care” budget. In the sections that follow, unless it is indicated otherwise, the “budget” under discussion is always the “care at home” purchasing budget. The sums of money allocated to this budget at the area level are generally quite modest – being in the order of £50,000-£80,000[3]. The 1991 Act anticipated that resources (for care at home) would flow to the point at which user need is assessed (Langan and Clarke, 1994). The legislation also directed that the front line social workers who assess care needs should assume new titles of “care managers”; titles which reflected their anticipated budgetary responsibilities.

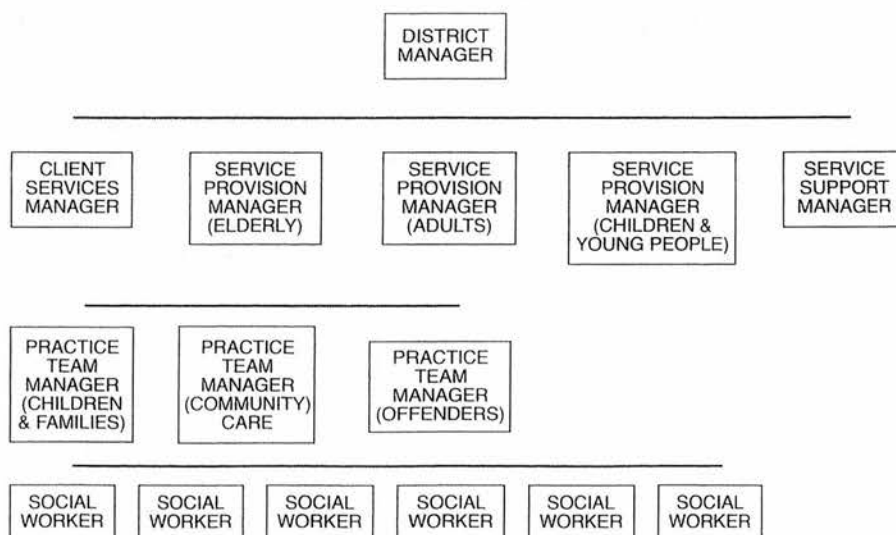


Figure 1.
Showing 4th tier
structure – operations

Organizational issues which negotiate the level of delegation

In the eight regional social work departments visited the anticipated devolution of budgets to care managers has not occurred. There are anxieties which surround the creation of the "care manager" role and in the authority visited in the case study the title of "care manager" had not been introduced:

A lot of people were very resistant to the care manager title. I think that they thought it meant deprofessionalization – that they would bring anyone in under that title (A4).

The deprofessionalization issue was also linked to concerns over the disappearance of "real" social work as front line workers were increasingly focused on administrative tasks to the exclusion of therapeutic work with clients:

Social work has been all about the professional personal relationship with the client which sought change on an individual level. It's not about that anymore – there just isn't enough money ... [But] social workers see files as an intrusion and they aren't used to thinking about the financial implications of what they are doing ... Workers are very resentful of this – of having to interpret government policy directly to users. They are working with people with very extreme needs and all they can do is just patch things up. It's a case of "shoot the messenger" and people are worried about being shot (A4).

Harmon and Mayer (1986) define problems such as "meeting needs" as "wicked" (as opposed to "tame") problems, by this they mean to imply that such problems "...have no definitive formulation, hence no agreed on criteria to tell when a solution has been found; the choice of a definition of a problem, in fact, typically determines its 'solution' ... [moreover] ... the solution itself potentially becomes a part of the problem..." (pp. 9, 11). In the social services the very definition of client "needs" (rather than, for example, "rights") both encompasses certain sorts of solution (for example, therapeutic support) and can exacerbate the problem (by ignoring the social structures of inequality which give rise to the disadvantage that is linked with client "need"). This analysis demonstrates that "wicked" problems are not amenable to standardized treatments nor can they be resolved through instrumental action. This implies that personal responsibility gains in relevance as the wickedness of problems becomes more evident. For wicked problems, personal commitment to the client is especially salient.

Where social workers are personally committed to their clients, accepting attributions of financial responsibilities will be particularly problematic. Practice team managers stressed the "emotional labour" (Langan and Clarke, 1994) involved if workers in face-to-face relationships with clients took on budgetary responsibilities for attempting "match" limited resources with unlimited client need. Consequently, there were pressures to avoid that burden by passing any difficult decisions over the acceptability of costly care packages to practice team managers (as they are at one remove from the front-line of care delivery). In this way practice team managers absorb responsibility for difficult financial decisions, reducing or deleting the responsibility of front line workers and preserving their advocacy roles:

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Workers would hate that [devolved budgets]. They disagree with some of the restrictions and they can still say "If it was up to me I would do this but it's not so I can't" (A1).

I think that they [front line workers] would find the budget intrusive in terms of their relationship with the client. Also if they had an awareness that they could only fund, say, a £60 a week service then there would be pressures to trim the assessment of need to meet that. It's much easier when they are advocates for the client and the manager makes the decisions (A3).

In some regions, in addition to the issue of protecting front line staff it was felt that the authority implied by holding a budget was inappropriate at the front line social worker level. This could be assessed by reference to the remuneration level of workers:

Practice team managers are paid about £20,000, so it seems OK for them to have budgets (R2/DD).

In other regions the finance office was reluctant to cede financial control to social workers who they perceive as lacking authority in the area of finance:

Also there's the finance office – they were anxious – they wanted to make sure that people knew what they were doing. Social workers don't have a great reputation for dealing with finance, there was a fear that we would get it horribly wrong. Also there's the control issue. Finance thought information is power and we've got it and you [social work] are not going to get it (R3/L).

Some social workers were also eager to preserve the boundaries between costing and caring (Llewellyn, 1998):

Workers don't like working with money, full stop. They find the whole concept of money difficult. People perceive that they are starting to be like accountants or auditors and that sits very uneasily with them – I just think that social work doesn't attract mathematicians – people who are numerate. As soon as you mention pounds, shillings and pence it gets people's backs up (A2).

The other main set of issues in determining the level of delegation and in keeping budgets away from the front line of service delivery were around fears that highly disaggregated, fragmented budgets would overly reduce flexibility in commissioning and impede the development of innovative practice based on a "wider" picture:

It's a balance between the feeling that it gives some useful flexibility when the budget is close to the client and the need to be consistent and have the ability to manage. You can decentralize until you haven't got the money to commission anything. Say every area got £5 to commission a fire service, well it just wouldn't happen but if those £5s came together at a higher level then it will (R5/L).

I think there are problems if decisions about money are taken a long way away from where the information is but then again it's not meaningful and smooth if you've only got the local picture (A1).

The above issues have all been implicated in negotiating the level of devolution of budgets in the social services. Budgetary responsibilities have not passed to front line workers, in part to shield them from the emotional labour with clients which having the authority to refuse or accept care packages would imply and, in part, to prevent the fragmentation of commissioning which would be

involved if budgets became too small. These issues have resulted in practice team manager level emerging as the lowest organizational tier to which budgets have been delegated. The next section explores the issue of how the individualized autonomies of practice team managers have been dissipated.

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How individual responsibilities are diffused and recast as collective ones

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The first issue examined is that of the authority-responsibility conjunction. In the social services authorities and responsibilities are often disconnected. The severing of the link between authority and responsibility occurs through vesting authorization for particular care packages at a different level of the organizational hierarchy from that of the financial responsibility for those care packages. In this way authority and responsibility become out of sync. In the areas visited the client services manager must authorize all "Level 1" care packages (a Level 1 care package meets the domiciliary needs of clients who would have to be accommodated in residential care if their needs were not met at home):

The other craziness is that I don't really have control over it [the budget]. X [the client services manager] effectively has control because he has to authorize all Level 1 packages. If we used Level 2[4] then I can agree it but we don't, so I don't have control. Really I'd prefer to be doing it or not doing it but as my personal relationship with X is good it works but with a different manager it would be impossible – but because of the way he works it's OK (A1).

While the above team manager construed the authorization/responsibility split as a "lack of control" issue, the person quoted below saw it as a negation of his responsibility:

Really the responsibility for the spend lies with the client services manager because all the placements are Level 1 and she has to authorize them (A3).

This team manager thought that authorization levels should be aligned with devolved budgets:

Budgets aren't truly devolved. We [PTMs] are perfectly able to make decisions about spending £500 but at the moment it's ludicrous because the client services manager has to authorize everything. Really it's about levels of authorization as opposed to levels of devolved budgets. If devolution is to be real authorization levels have to be freed up. At the moment it's ridiculous because she [client services manager] is even further removed from the field than I am (A3).

In contrast, the next team manager saw the authorization as "rubber-stamping" and perceived that he retained responsibility for the budget:

Strictly speaking only the client services manager can authorize Level 1 – that's just been introduced in the last couple of weeks. But, personally, I feel responsible, I meet with the local administrator [in-service support] on a monthly basis to go through things (A2).

The second issue which diffuses individualized responsibilities for budgets is the existence of multiple sources of budget access. Clients who are discharged from hospital are assessed by the hospital social work teams but "hospital" budgets only cover the first four weeks after discharge, subsequent to this the cost of the package is transferred to the client's geographical area of domicile:

There are demands that I have no control over. Discharges from hospital, for example, I just have to accept as a charge on my budget. I could, in theory, challenge the assessment but it would be very unusual for me to do that and I'd have to challenge the assessment in order to argue about the cost (A2).

The area hospital practice team manager expressed it this way:

Really I'm committing money from other people's budgets without asking them. If I wanted to be particularly courteous I might ring someone up but I certainly don't have to ... Really I'm in a lucky position because I'm only making commitments for a four week period and then the responsibility reverts to the area team of origin. Also people tend not to question the assessment because that would take forever and the discharge would be delayed. It means that the locus of responsibility is moved outwards (A3).

Another non-controllable charge on the "care at home" budget is the resourcing of community service volunteers:

Before reorganization we had a budget for community service volunteers but with reorganization that budget disappeared and they are now paid out of the "care at home" budget. Now for the particular client I'm thinking of there is no way that she meets the Level 1 criteria but the care for her is being paid out of the budget because she is cared for by these volunteers – these are things I don't feel comfortable about but there's nothing I can do (A1).

Yet another access issue which diffuses individualized responsibility is the practice of borrowing from the purchasing budget to resource the provider budget:

There are lots of other sorts of madness around. The "care at home" budget [purchasing] is sometimes paid into the home help budget [provider] because the home care service is under-resourced. That bit of under-resourcing would show up on the home care budget if it was all one pot – the distinction is often silly (A1).

The existence of these multiple sources of access to a budget which is supposedly only to fund "care at home" exemplifies how attempts to further internally divide and partition the organization (through the creation of individual loci of responsibility within the purchaser/provider split) are diffused through sharing strategies.

A third source of diffusion of responsibility is through the use of prescriptive organizational rules on how moneys can be spent:

Really there's no sense of a devolved budget that allows me to do what I want because I have to go with departmental policy. I've got to spend on our own services first. If I go to the private sector they have to be a listed supplier that we [the department] have agreed to contract with and there are things I can spend money on and things I can't – for example, I can't buy nursing care – that comes out of the health budget (A3).

My political views are of the left but there is a dogmatic adherence to socialist views which makes the home care service totally ineffective and a bad use of resources. The private sector are barking at the gate but there is a political imperative to use our own services first, then the voluntary sector and then the private sector (A4).

Such rules avoid the situations of attribution of individual blame which can occur where calculating selves (Miller, 1992) transact in a market. The retention of prescriptive organizational rules "...protects collective action from the intrusion of irreconcilable personal differences, and it also realizes a presence in

local contexts that threaten to uncover and thereby perhaps inhibits the personal abuse of power" (Roberts, 1991, p. 364). In this context adherence to the rule which dictates that the local authority's own home care services must be privileged, prevents the personal, politicized differences in opinion between team managers on this issue becoming publicly apparent; the rule also stops differing decisions being made on the extent of the use of the independent sector and deflects any possibility of inducements to make placements being offered to team managers from providers in the independent sector:

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If at all the pressures are likely to come from the opposite direction [from providers rather than purchasers], homes offering a £5 discount or social workers being given backhanders, God forbid, I must say I've never heard of it (R6/C).

The price to be paid for the reduction of conflict between team managers and the containment of potential abuses is a service which is less than fully effective and does not make the best use of resources. However, the blame for a less good service cannot be attributed to any particular team manager as all decisions on the allocation of resources in the independent sector will be similar. Roberts (1991, p. 364) points out, "The paradox is that abuses then reappear in the other sphere [in this context, the service delivered to clients] in the form of the apparently unintentional injuries of inequality and disadvantage which are personally damaging but whose origin, or causality is difficult to specify". If there are to be individualized attempts to secure the "best deal" for clients within the constraints of a strictly limited budget, the result will be individualized attributions of responsibility:

For devolved budgeting to be real there should be no artificial ring-fencing. It should be that's your budget and you try to get the best deal for your client in the marketplace. I think we could put some very creative arrangements in place if it was like that. But the downside would be that it would be terrifying if you've got a budget which has run out and you are left wringing your hands and you've got people screaming at you (A3).

The above evidence demonstrates how the processes of disengaging levels of devolution from levels of authorization, of allowing multiple sources of access to budgets and of using prescriptive organizational rules result in the dissipation of individualized autonomies and the continuance of shared forms of responsibility. Within this context budget-holders are not held responsible for budget overspends and tend not to experience a sense of ownership of the budget:

Really if someone overspent on their budget there was a feeling that it would be wiped away in the blink of an eye (A2).

I don't know how responsible the other area PTMs feel for their budgets – a lot have said that this is the department's money and I've been allocated it in name only. They don't feel that this is a budget that they have to worry about (A3).

I informed him [the client services manager] about the budget overspend and said I was anxious but there was no response and things just carried on as normal. The culture is that we have covered our backs because we have expressed concern ... There was no sense that this was important, it was as if the budget was something in the ether (A4).

Budgets are ethereal because overspends can be lightly dismissed; they don't carry weight in the social services context because they are not aligned with operational activities. Ultimately practice team managers put their responsibilities to meet client need before their responsibility to manage a budget. The impossibility of balancing the moral imperative to meet needs with the financial responsibility to apportion very limited resources in relation to that need is the basic unsolvable problem (Brunsson, 1990) in the social services. The result is a budget that is not meaningful:

There has not been a departmental culture where being underspent or overspent has meant anything (A3).

The next section extends the discussion of the complexities of using budgets to ascribe responsibilities in the context of the social services.

Discussion

The evidence from the social services is that there are still boundaries in place (Llewellyn, 1998) between the responsibilities for operational, social work activities and the responsibilities for the budgets that resource these activities. These boundaries are maintained through adherence to various rationales (the avoidance of "emotional labour" for front-line staff; perceptions of how far it is appropriate to trust lower level employees with budgets; and prevention of undue budget fragmentation). These issues support a separation of duties between face-to-face work with clients and financial management. The result is that budgets are held away from the front line of service delivery and team managers are the lowest organizational tier to which budgets are delegated. Consequently, in terms of responsibility for "assigned tasks", the task of "matching needs and resources" anticipated by the Audit Commission (1992) has not been allocated to individuals but remains as a series of responsibilities fragmented between client services managers, practice team managers and front-line workers. It is understandable that social work personnel in the context of matching needs and resources reject the assumption of individual moral agency, for the result of an explicit matching of needs and resources will be a denial of service to certain clients. Individuals are unlikely to wish to be seen as moral agents in these circumstances.

The previous section has discussed how the formal individual financial responsibilities of team managers are recast as collective ones. These diffusion processes operate vertically; both through authorization being passed back up the hierarchy to client services managers and through adherence to top-down rules that prescribe what moneys can be spent on. Diffusion processes also operate horizontally, through allowing multiple sources of access to the budget. These diffusions of financial responsibility result in the differing perceptions of personal responsibility reported on in the previous section. Some team managers feel responsible for their budgets; some do not – thinking that their personal responsibility has been dissipated either by allowing other people

some control over “their” budgets or by having to follow organizational rules that constrain their decisions: Pushing budgets
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There is a lot of ambiguity. There was no clear statement about where the cut-off point is. There's a real lack of clarity and the department gave out very mixed messages. The results are that people feel differently – some people take a very personal view of the spend and their responsibility for it but in other cases there is no ownership and no anxiety even though there are massive overspends (A3).

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This quote demonstrates that even where there are severe effects (i.e. “massive overspends”) these do not always give rise to feelings of personal responsibility. This situation violates the commonly held assumption that more responsibility should be attributed when the effects of action are serious than when they are relatively trivial (Shaver, 1975, p. 109). This discrepancy seems to be explained by differential perceptions of the extent of the personal control of the budget-holder; people feel more responsible where they think that they have more control over the effects of action (Shaver, 1975, p. 104). Where budget holders do not think of themselves as “producers of effects” they attribute the responsibility for the budget to the ambiguous situation within the department, but, as the above quote demonstrates, such attributions are unsatisfactory as they do not make organizational events more meaningful.

Despite all the ambiguity there does remain a sense in which team managers are primarily responsible for managing financial resources, but two main issues confound their responsibilities for this financial management task. First, front-line workers are charged to carry out need assessments without regard to their cost consequences or to the availability of resource to meet the assessments:

Of course we fall between the twin stools of having a finite amount of money and having an open-ended service to meet ends (A4).

The problem is, where does the responsibility lie if need is assessed at a certain level and then we can only provide the money to meet a part of that need? Then what if something goes wrong, how do we explain that to people? (A3).

In these circumstances numbers of clients with assessed need accumulate without regard to whether or not resource is currently available to meet those ends.

Second, there are no agreed rules on prioritization to allow for any rational ordering of these clients:

We should have clear priorities and time scales and we should publish them as information for clients but when it came to it the director wouldn't agree to any publication of information. We have people on the waiting list who applied in 1994 and they haven't heard a word since – we have to say to them that we can't tell you when you will be seen. There is a culture of paranoia. We are not prepared to publish priorities and time scales because of a fear of exposure – of appearing to be unfair and so generating a complaint. So what happens is that if people do complain then they get, but if they don't then they don't get, which is unfair (A4).

I don't know who decides how the budget is shared out. We should have more clarity and consistency to work out clearly who gets what but it won't happen because you have to make clear public statements. Instead we have muddle and it boils down to whether you argue in the right way to the right person (A1).

The above quotes illustrate the point which Brunsson (1993) makes about things which can be done but cannot be said, "Ethical norms tend to limit what we can say more than what we can do. It is easier to implement actions which are regarded as immoral, than acknowledge them openly; and it is even more difficult to defend them or to propose that they be adopted" (p. 492). In the social services context the director fears that the open discussion and publication of priorities would lead to accusations of unfairness, hence there are no such discussions or publications and no clear priorities – arbitrariness reigns.

The Audit Commission (1992) appeared to anticipate that the implementation of prioritization would be unproblematic, "Members must decide on competing priorities between dependency levels and user groups, setting criteria for different levels of assessment, care management and services" (p. 26). The problem with such statements is that they ignore the possibility of reactions from "de-prioritized groups" if they become aware of their position through publicly available information.

Where resources do not match with assessed needs and prioritization is not implemented, budget overspends can only be avoided by queuing or by a denial of service. Waiting times were lengthy in all the areas visited (with the exception of discharges from hospital) but any decision to withhold services to avoid budget overspend is seen as unacceptable and, in any case, one which would have to be taken at departmental level:

No one says that you have spent your money so the shutters are coming down (A2).

Basically I would see it as a departmental policy decision if we decided to pull down the shutters if the budget was overspent (A3).

Where responsibility cannot be clearly attributed to delegated individuals and there are no unambiguous rules for collective responsibility, loci of responsibility shift arbitrarily. In these circumstances responsibilities may be seen to lie ultimately with a central ruler (Wildavsky, 1986):

There is a climate of fear in the department. People are afraid that the Director will pick up the phone and given them a b...ing. The hierarchy is very steep and people are scared to do anything without getting permission from their manager as things get fed up and down the hierarchy. Ultimately it's a dictatorship where the Director says "No" (A4).

But, as the above quote demonstrates, rather than generating perceptions of the director as a sovereign leader, the absence of unambiguous attributions of delegated responsibility gives rise to a dictatorial ethos. Within this ethos the notion of hierarchy implies that financial responsibility can still be vested in the organizational leader (Brunsson, 1996). But these perceptions of the ultimate financial responsibility of the director are at variance with the principles of delegated budgets.

Where there are neither clearly responsible agents with individualized autonomies to set priorities nor unambiguous sets of rules to underpin collective responsibility, devolved budgets cannot be used to plan service delivery nor can they be used to control processes of prioritization. In these

circumstances budgets are disengaged from organizational activities and responsibilities focus on service delivery:

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You can't say that you are managing a budget because at the end of the day we are meeting needs (A2).

I suppose I'm ambivalent about my budgetary responsibilities. I'm a member of a social work department with a range of responsibilities but I see myself first as a manager responsible for service delivery. Within that I should seek to maximize efficiency and to do that I see it as perfectly appropriate for me to have responsibility for the budget. But first I should be confident that the assessments that are made are accurate and no one is, say, going into care who shouldn't be. You can't say that being accountable for a budget means that you will stop making residential home placements (A3).

The message I have given staff is that I don't want needs not to be met (A2).

In the beginning we were given strong warnings about what to do if we were over-committed but now we are and no one says anything. People argue on the basis of need and that's the end of story (A1).

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Despite some perceptions of the ultimate personal responsibility of the director, the day-to-day responsibility for care packages is a collective one, where a front-line social worker devises and costs the package, the team manager then looks at the costs in relation to the assessed needs (and may attempt to negotiate the costs downwards) and the client services manager gives the authorization. Thus, although the practice team manager is nominally responsible for the budget, the operational activities which the budget resources are the preserve of front-line workers, with the final authority for operations lying with the client services manager. A socialized collective responsibility exists for care packages:

Really the budget responsibility is shared... We accept that we are all singing from the same hymn sheet (A4).

Therefore, despite attempts to use budgets as mechanisms to attribute individualized financial autonomies there remains a strong sense of collective responsibility – albeit that these collective responsibilities are not currently underpinned by any consensual normative principles.

Concluding comments

Delegating budgets in the social services has failed to create individualized responsibilities. Having noted this, the question remains of whether this is a residual control problem or whether there are more fundamental issues at stake here. If the former, a tightening up of management practices would be prescribed, so that authority and responsibility become conjoined in one person, multiple sources of access to the budget are not permitted, and prescriptive organizational rules are relaxed to permit more individualized choices. This approach would view the issues outlined here as difficult, but ultimately transitory ones, as individualized responsibilities emerge. On the latter view, the introduction of devolved budgets into social work departments in a context of resource constraint and a lack of clear prioritization will fail, because, in

these circumstances, the responsibilities which workers feel for basic social work values cannot be successfully aligned with their new financial responsibilities. This latter view would indicate that, as individualized responsibilities will not work, accounting systems must seek to support collective responsibilities.

In balance, it is judged here that the narrative account in the paper supports the view that there is a fundamental problematic here. If this is the case is there a contribution which accounting can make to the dilemma? One approach would be to argue that accounting should, in circumstances of collective responsibilities, return to the values of narration and acknowledgement (along with a jettison of any exclusive focus on control), so that informative accounts emerge that clarify who got what and when and how (Nelson, 1993). There is certainly scope for such narratives in the social work context where the number, cost and complexity of the care packages funded would be informative in terms of planning and the written acknowledgement of multiple access (and borrowing) would make visible practices which are currently anecdotal and not always quantified. Another approach would be to recognize that in an ambiguous situation, such as that portrayed here, accounting measures should be focused on being communication-efficient (Lindkvist, 1993). Communication-efficient accounting would provide for measures that are simple, unambiguous and predictable in how they mirror various contingent events. Simply that team managers always know where they (and colleagues) are against budget and that they are aware of the magnitude of next year's budget in good time would provide some accounting certainties in a very uncertain situation. Recognizing that in ambiguous situations there is a limit to the sophistication that accounting can assume, provides more organizational space for talk (or socializing communication) in an attempt to rebuild consensual normative principles.

From the two approaches suggested above, commonalities emerge. One can conclude that in professionally based, decentralized work organizations where ambiguity is inherent, accounting measures should jettison control for communication, seek simplicity over complexity, and be tied up with informative narratives rather than focused on isolated representation. Appropriate accounting practices to support collective responsibilities or co-operative models (Lindkvist, 1996), rather than individualized autonomies, are yet to be developed, but the argument of this paper is that such practices should be based on communication, simplicity and narration.

Notes

1. There was some restructuring of the social services departments between the first and second stages of the research. Regional authorities have been split into smaller "unitary" authorities so although the authority which is the focus of the more intensive investigation had participated at the first stage, by the second stage it had been split into four unitary areas.
2. The types of expenditures allowed under the "care at home" budget cover any items which will support a client in staying in their own home (rather than entering a residential home),

and include moneys for home-helps, meals on wheels, night-sitting, and the provision of equipment (such as stair-lifts).

3. Although these sums are relatively small at the area level, purchasing is an increasingly important activity within social work. There has been a doubling of the percentage of the total social work budget spent on purchasing in three years and this percentage now stands at over a third (*Purchasing Strategy*, 1995-6).
4. A Level 2 care package is devised to meet the needs of a client who has been assessed as requiring support in order to enjoy a reasonable quality of life in the community but whose needs are not so great as to immediately precipitate entry to residential care if the package is not authorized.

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SURGEONS ARE COUNTERS, PHYSICIANS ARE PHILOSOPHERS: MANAGING SURGERY AND MEDICINE DIFFERENTLY

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ABSTRACT

The financial management of health care poses difficult challenges. Resource allocation is driven by the decisions of senior medical professionals who have enjoyed a high degree of autonomy in their decision-making and who have not been accustomed to being subject to cost constraints. In an attempt to imbue doctors with a more managerial ethos the clinical directorate structure was introduced into hospitals in the UK. This initiative created some senior doctors as clinical directors with budgetary responsibilities for their particular specializations. This article draws on interview material to explore the responses of clinical directors to management, particularly focussing on the differences between surgeons and physicians in this respect.

It was found that surgeons had more alignment with managers in so far as they displayed the putative managerial characteristics of strength, boldness and aggression with a bias for decisive action. Surgical work was also found to be more penetrated by the management categories of standardization, centralization and bureaucratization, leading to the easier establishment of efficiency and productivity criteria. These conclusions indicate that in an environment characterized by resource scarcity, surgeons will be able to demonstrate their resource needs in management terms. In contrast, physicians showed less enthusiasm for management tasks and medicine was less transparent in both activities and outputs, than was surgery. Physicians still argue for financial resources in the traditional way—*i.e.* on the basis of increased need. The article concludes that surgery is more open to the techniques of scientific management whereas managing medicine will be more of an art than a science.

Surgeons are trained to count numbers. I have been coding every operation since I started here. I was trained to do this. (BCD1S)

It is curious how different specialisms attract different personalities. Also principles and time scales can vary. For example, physicians are philosophers... (CCD4S)

Health care presents a unique and problematic context for implementing management techniques (Bates & Brignall 1993; Howes 1994; King *et al.* 1994; Ellwood 1995, 1996; Jones 1999; Jones & Dewing 1997; Soderlund *et al.* 1995, 1997). However the very perception that the management of health care is unique has fostered the adoption of blanket approaches to cost control, as if the problem of

managing medicine has a single solution. Overall prescriptions for cost control, for example, devolved budgeting or diagnostic related group (DRG) costing, have been applied across all medical specializations. Such a generalized approach to the management of medicine reflects the contemporary myths of unity that characterize health care (Llewellyn 1997). Such myths have militated against an understanding of the very varied types of work that take place within medicine. In contrast, recognition of the heterogeneity of clinical work opens up the possibility of differentiated approaches to management control for the very different types of activity and output across the health care area. This paper explores some differences between surgery and medicine with respect to management.

As surgery and medicine have the same focus—the human body—differences between them have been obscured,

...we think that fixing a broken thumb is "closer" to curing typhoid fever than it is to building a bridge, because of the common object of the first two tasks, the human body. But in purely theoretical terms, broken bones are close to bridges because both involve the science of mechanics. Indeed, the physicians who handle the fever and the surgeons who fixed the thumbs had little to do with one another before the nineteenth century. (Abbott 1988, p. 36).

Clinical work operates through techniques that are part art, part science (Klein 1995, p. 250). In this mix surgery is a technical craft of applied science whereas medicine is more an art of applied science. The distinction between surgery and medicine operates through the recognized division of labor attached to the bodily systems they both investigate. For example, for the cardiovascular system, cardiac surgery and medical cardiology are established; for the respiratory system there is thoracic surgery and chest medicine; for the gastrointestinal system, abdominal (or general) surgery and gastroenterology and so on (Armstrong 1993, p. 237). Abbott's perception that surgery is aligned with the science of mechanics fosters the view that greater standardization is possible in surgery. Moreover in terms of scientific advance, technology is likely to further transform all clinical work, but most particularly the practice of surgery (Klein 1995, p. 247). Hence surgery looks set to be even more driven by rationality and standardization and to become the firmly established "technical core" (Macintosh 1985, p. 164) of clinical work. Protocols and guidelines on best practice are most easily applied in standardized situations of technical rationality (Klein *et al.* 1996) and, therefore, may be expected to penetrate surgery to a greater extent than they do medicine. In turn the increasing use of protocols and guidelines will lead to more convergence in practice as surgery is delivered to pre-specified standards.

Medicine is characterized by greater uncertainty, as diagnosis tends to be more problematic and the links between diagnosis and treatment more difficult to establish. Physicians often deal with patients (especially older ones) who have multiple problems with unclear prognoses. In situations of uncertainty Abbott (1988, p. 49) argues that inference (reasoning from problem to solution) works by exclusion or

construction. Medicine works by exclusion. If a case is unclear than doctors maintain a general supportive treatment while ruling out areas by using special diagnostic procedures. Physicians (unlike, for example, the military who work by construction—hypothesizing enemy responses to their tactics) have the luxury of “second chances” they can find out what does not work and then move on in the hope of finding something that does (Abbott 1988, p. 49). Surgeons do not have the same opportunity (as do physicians) for second chances; surgery tends to be focussed on a single diagnosis with a specified operative procedure, usually an operation is performed only once and there is an expectation that it will be done correctly first time. As physicians reason by exclusion and take advantage of second chances, factors like length of stay and number of diagnostic tests are less easily standardized in medicine (as opposed to surgery). The higher uncertainty in diagnosis and treatment in medicine gives rise to the greater use of “...experience, trial and error, intuition and muddling through.” (Schon 1991 p. 43). In turn this is likely to result in less predictable, more idiosyncratic practices in medicine and, hence, greater cost variability. In turn this implies that cost control will be more problematic in medicine than in surgery.

Differences both in the practice of medicine and surgery and in the character of physicians and surgeons affect the relationship between clinical and management agendas. This article explores how these differences impact on the ways in which clinical directors (doctors with management responsibilities) approach their work and the ways in which cost management techniques have penetrated surgery and medicine. These differential effects indicate the likelihood of greater success in the management control of health care if different strategies are applied in surgery and medicine. Before these differences are discussed the research method of the paper is explained.

THE RESEARCH METHOD AND THE RESEARCH SETTING

This project involved interviews with sixteen clinical directors from three different Trust¹ hospitals in the UK. The directorate structure at the hospitals varied. The first Trust has eight directorates, two at specialty level, five sub-specialties and a support service: surgical; medical; neurosciences; oncology; theatres and anaesthetics; imaging; laboratories; and (at a separate site) a geriatric unit. The second Trust has three: medical; surgical; and a support directorate. The third Trust has five directorates, two at specialty level, one sub-specialty, and two support directorates: general surgery; medicine; obstetrics and gynecology; clinical resources; and diagnostic and paramedical services. A consultant heads up all the directorates, with the exception of one—the clinical director of clinical resources at the third Trust has a background in pharmacy. In the empirical material cited below the Trusts take the letters of “A,” “B” or “C.” The clinical directors are numbered and identified as surgeons (S), physicians

¹ Trusts are semi-autonomous self-governing hospitals that are directly accountable to the Secretary of State for Health in the UK. They may set their own levels of remuneration for their workforce but are subject to external financing requirements that limit total borrowing for capital projects. They must also earn a 6 percent return on assets in use.

(P), anesthetists (A), obstetricians (O) or doctors in charge of a support directorate (SU) *e.g.* ACD1S is one of the eight clinical directors at the first Trust and is a surgeon. This labeling, while preserving public anonymity, gives the reader knowledge of the clinical director's specialization and allows comparison of response on different issues if the doctor is quoted more than once.

Each clinical director assumes total responsibility for her/his department, reporting directly to the medical director (also a clinician but a member of the executive team that includes directors of other functional areas such as finance, nursing, human resources and corporate services). The executive team (along with the non-executive directors) report directly to the Chief Executive. This structure gives the clinical directors two management roles: first, as directors of clinical units and, second, as members of the corporate management of hospitals. Within each directorate there are a business manager and a nurse manager both of who report to the clinical director.

Clinical directorates are management units formed around clinical specialties. The intention is that each unit has its own budget for financial management purposes and seeks contracts with purchasers to supply hospital services (Walby & Greenwall 1994a, p. 149). This structure was inspired by the John Hopkins Hospital at Baltimore in the US and sought the active involvement of clinicians in resource management in the recognition that hospital costs are largely determined by the decisions made by or authorized by senior doctors (Hunter 1992; Preston 1992; Jones & Dewing 1997). Clinical directorates are governance structures which put medical (rather than non-medical) managers in positions which have some authority over the decisions made by their colleagues under the assumption that clinicians will be more likely to respond positively to management agendas set by medical (rather than non-medical) managers. The underlying logic is to make doctors into managers by giving them the freedom to conduct their directorates as semi-autonomous, self-managed units (Ezzamel & Willmott 1993); along with this freedom comes a measure of financial responsibility.

The research design was qualitative and exploratory. This was felt appropriate given the relative brevity of the clinical directorate structure for the hospitals concerned (being about three years in duration) and the still dynamic nature of the processes under consideration. Semi-structured interviews of two hours duration were undertaken with the clinical directors and included the following areas: a history of clinical directorate involvement; the role of clinical budgeting and the relationship with non-medical management. The interviews took the form of guided conversations (McNeill 1990) where the clinical director pursued topics and raised themes of interest within the broad prompted areas indicated above. The aim of the interviews was to discover what was "in and on" the minds (Patton 1990, p. 278) of the clinical directors regarding the conditions and consequences of their involvement in management tasks. In order to discover what was "in and on" the respondents' minds, the clinical directors controlled the introduction and flow of topics² and no attempts were made to

² With the exception of a first question which asked for a history of their involvement in the clinical directorate structure.

keep the respondent "to the point." The key theme of the differences between surgery and medicine with respect to management emerged during the research. This theme was subsequently highlighted as significant through the use of context appreciation and narrative analysis (Agar & Hobbs 1982; Mishler 1986).

The next section addresses the evidence from the clinical directors on their experiences as doctor-managers and their relationship with non-medical management, particularly focussing on the differences between surgeons and physicians. The narratives of the clinical directors have been shaped into "meta-stories" (Reissman 1993) that transcend their personal experiences. The aim was to edit and shape the interview material in such a way as to bring out the organizational significance of what were, originally, individual accounts.

SURGERY AND MEDICINE ARE DIFFERENT (AND SO IS THEIR RELATIONSHIP WITH MANAGEMENT)

One of the clinical directors (a surgeon) introduced a discussion on the differences in attitude between surgeons and physicians through reciting a joke:

Have you heard the one about a physician, a psychiatrist and a surgeon shooting ducks?—it just about sums up the differences...Well a physician, a psychiatrist and a surgeon go out to shoot ducks. The physician raises his gun, aims, then lowers it, saying "I'm not sure if that was a duck." The psychiatrist aims but then pauses, saying "But does that bird know that it's a duck?" Meanwhile the surgeon fires and the bird falls to the ground, he turns and says to the pathologist "Go and make sure that that's a duck." (BCD1S)

The great techniques of medicine: inference, the taking of the patient's history and clinical examination (Armstrong 1993, p. 236), map onto the practices of medicine, psychiatry and surgery. This joke plays upon these classic divisions in clinical work through puns on their associations with uncertain supposition, patients' self-knowledge and clinical foresight. It also conveys clinicians' perceptions of the personality differences between surgeons and physicians, differences that reflect (and are reflected by) their work. The implications are that physicians hesitate and, therefore, miss opportunities, that psychiatrists cannot act unless their interventions are validated by their patients but that surgeons have a bias for bold actions, are content to take risks and are accustomed to discovering whether their actions are completely appropriate (or not) after the event.

The action-oriented nature of surgical work is aligned with the male values of heroism and efficacy that pervade the management literature (*c.f.* the work of Drucker 1968 and Peters & Waterman 1982, portraying the super-hero leaders of business). The characteristics of strength, boldness and aggression implied by management and leadership (Mills 1993) are also displayed by surgeons. "Super-hero" surgeons rely on the cultural values of strength, heroism and efficacy to legitimate their interventionist health care (Abbott 1988, p. 188). These similarities in values, beliefs and practices imply that surgeons are more "naturally" aligned with management's bias for action

than are physicians. The action-orientation of surgeons was mentioned by the anesthetist and physician (respectively) quoted below:

Surgeons are doers, their clinical skills make them more direct people, they have a clear view of what they are doing and they aren't too philosophical. (ACD6A)

There is a big difference in mentality. People joke about it—surgeons—if in doubt, cut it out, but as in all jokes there is an element of truth. Although physicians are becoming more interventionist so there's a blurring of the boundaries. But surgeons do want to do something to sort things out. (ACD2P)

The putative managerial attribute of decisiveness is linked to surgeons' more practical mentality. The interventionist nature of surgery allows surgeons to actually see the pathology they have diagnosed and this visualization confirms their expertise, "...in cutting the surgeon was [also] able to see the disease (Armstrong 1993, p. 236). As surgeons have more opportunities to visualize than their colleagues in psychiatry and medicine do they tend to be more confident people; seeing engenders more certainty than history or inference. Surgeons also exercise their practical skills in theatres (arenas for public display) where they are accustomed to their professional competence being immediately visible to their colleagues. This requirement to demonstrate competence in front of others and under time pressures involves surgeons in making (and defending) quick decisions, often ones with important consequences.

There is an element of truth in that there are major personality differences between surgeons and physicians. Surgeons make faster decisions and their decisions can be more far-reaching. One could say that that's more in keeping with management. Physicians can think too long and miss the boat. (ACD3S)

As their work involves rapid decision-making the surgical clinical directors valued what they perceived to be the more efficient management structure to support decision-making that Trust status (and the health care reforms in general) had conferred.

I would say that this used to be a very democratic place, decisions never happened because they got bounced around all over the place. Now the Trust management group can make a commitment, the whole process is less cumbersome. It used to be that if there were two people missing from a meeting, well someone would say so and so's not here and then you would be talking four months before anything happened and even then it probably wouldn't, people knew that no answers ever popped out. (BCD1S)

In so far as management involves action, intervention, leadership and decision-making (Newman & Clarke 1994), surgeons have more alignment with managers than do physicians. However management extends more widely than this and encompasses

tasks that may be better adapted to the personalities of physicians (or as in this quote, psychiatrists).

Actually I think that clinicians are suited to different types of management role. Physicians are deeper people. If you want someone who has the patience to negotiate with the health board and who can think through the issues then I would go for a physician. If you want someone who can say, "You should move 8 beds and knock down that wall" then you need a surgeon. If you want someone to deal with difficult people then you should go to a psychiatrist. (BCD1S)

The above quote expresses the notion that surgeons and physicians should be channeled into different management tasks. The idea that the practice of management may penetrate and impact on surgery and medicine differently is explored next.

As surgery involves an action sequence, is of an interventionist nature and takes place within a limited time period it has clearer outcomes (than does medicine). Surgical work is, therefore, more amenable to counting and measurement.

Surgeons are trained to count numbers. I have been coding every operation I do since I started here. There is a history of 50 years of surgical audit in this region, it started in 1946, there's a database going back to then. I've got information about the numbers of types of operation I have done, things like for 500 consecutive operations I have a 1% mortality rate. I was trained to do this. Our outcomes are more clear cut than physicians', you can count the number of operations, for example. Physicians sit in offices and speak to patients much more and their outcomes are much more ambiguous. (BCD1S).

As surgical outcomes can be counted and measured the possibilities for standardization and, the consequent penetration of cost-effectiveness discourses into clinical work look to be greater for surgery than for medicine. The practice of medicine is more complex and open-ended than is surgery and tends to involve multiple treatments rather than a single operation for a specific condition.

Also physicians are intrigued by pharmacology, they work with a lot of drugs and their patients tend to be older and have lots of diseases in one body. Here in obs and gynae it's more of a screening exercise to rule out specific maladies, it's more circumscribed. (CCD4O)

A clinical director who heads up a support directorate commented on the consequences of the complexity of medical practice in terms of trying to establish an agreed volume of laboratory tests with the physicians.

Physicians can't manage their work load so the labs have to roll over, we have no way to limit the volume. I have said to the physicians that they must establish

a volume with no re-openers. I know service level agreements use a lot of resources but otherwise clinicians work by relaxing into clinical mode. We could start them [service level agreements] with historical activity. (BCD2SU)

This clinical director is proposing a management-type solution (service level agreements) to the problem of limiting the volume of laboratory tests but the actions of the physician quoted next indicate that managerial solutions (in this case, devolved budgets) have not, so far, worked well in medicine.

I am totally concerned with providing good clinical care within the constraints of clinical practice. I had a £300,000 overspend last year but I don't really care because if I stayed within budget I wouldn't be able to function. (CCD2P)

Clinical directors who are physicians (as opposed to surgeons) are more inclined to emphasize their clinical advocacy role within management and to play down (or even reject) their financial responsibilities.

I see my role as representing the views of my medical colleagues very forcibly to the management team and the chief executive. (CCD2P)

In contrast to this, the following comment exemplifies the view of the surgical directorates where surgeons are more willing to look at issues from a "corporate" standpoint.

We all know the reality of the situation. To an extent I have to distance myself from general surgery. Sometimes I have to follow a path which is not in the best interests of general surgery because what we are doing is in the best interests of the Trust. (BCD1S)

The stronger advocacy of the medical clinical directors is linked to their aspirations for clinical excellence in their field (such aspirations are, of course, shared by the surgeons but in the surgical directorates there is a greater propensity for advocacy to be mediated by perceptions of corporate and financial responsibilities). Hence the medical clinical directors were more likely to feel that health care financial management reforms should be, always and only, directed toward the enabling of excellence in clinical practice. While the surgical clinical directors expressed more opinions on the importance of the reforms in integrating clinical and management agendas in order to develop health care into a more effective allocative system. In this sense the surgeons showed more interest in the "macro" problems of health care (*i.e.* care focused on the characteristics of populations as opposed to "micro" care which is governed by satisfying the needs of individual patients [Scott 1982]). In terms of the likelihood of clinicians turning their attention from medical practice to the problems of the larger health care domain (Schon 1991, p. 14) the surgeons did this more often. The first quote below is from a physician, the second and third are from surgeons.

You are asking me about the reforms? What's important? I'll tell you what's important. What's important is trying to run a service for people with cancer that is second to none in the world, to be at the forefront in oncology treatment, to aspire to excellence and to look after patients in the best way possible. (ACD7P)

We started with management budgeting back in the early 80s but it went down the tubes because there was no clinical involvement. I've always felt that clinical and management teams should work as one unit rather than working on parallel tracks. (CCD4O)

It has to be a two-way process, why should we expect managers to understand what we do if we don't understand management. (ACD3S)

Surgeons have higher hopes of productive two-way exchanges with management than physicians do.

We have a good dialogue with the non-medical managers. We [the clinicians] were involved right from the start [of the reforms]. I think it's been different in other Trusts. We set up the management structure, which is a good one. Also there's been an interchange of ideas and receptivity on both sides. From the beginning we had a very open exchange which I don't think exists in all the other Trusts. (CCD1S)

I'm not entirely convinced that we talk about the things that need to be addressed—like how do we retain good staff in today's environment, how do we motivate people, the important issues. The level of discussion is not as fecund as it might be—it's a little bit sterile. (CCD2P)

Overall the medical clinical directors hold a generally less positive attitude toward management than do the surgical ones. The argument of this section has been that this stems, in part, from differences in character between surgeons and physicians and, in part, from the nature of medical work, which is more open-ended, involves more trial and error in treatment and, hence, is less easily standardized than surgical work. The trajectory of medical work is more difficult to compartmentalize into managerial categories such as efficiency and productivity and, therefore, physicians cannot argue for more resources in scientific management terms. The result of this is that physicians are skeptical about the value of management techniques such as devolved budgeting.

I am disillusioned because a lot of the change has remained theoretical....We've never looked at budgets...in truth there has never been anything like transferring a block of money from surgery to medicine, everything is pre-arranged. (ACD2P)

The medical clinical directors also express more dissatisfaction with budgetary constraints,

The degree of autonomy which is theoretically awarded to clinical directorates just doesn't exist. The yearly negotiations—really there is no negotiation—we are told that we are getting this. Budgets aren't geared to activity levels, which are 25% up. (CCD2P)

and even speak of the “perversions” of cost pressures.

There is a process of peers being perverted by cost pressures, it's a very negative holding back type of feeling. I don't know why we can't concentrate on some positive goal like expanding our services into X region but they [managers] always seem to be holding back, there's a certain inevitability about it. (ACD7P)

Whereas the surgical clinical directors, while naturally not pleased by budget cuts, were more positive about the advantages of devolved budgets,

In obs and gynae we were pleased to get control of the budget. It meant that we could decide on our own priorities even if it was against a backdrop of overall budget cuts. Mind you we weren't pleased to be asked to meet the 3% efficiency savings (which were across the board) because we thought that we were more efficient in the first place. (CCD4O)

and more willing to accept that cost awareness and cost control are now elements in the practice of clinical work.

I think that there has been a sea-change in clinicians' attitudes—quite a material change from there being a small core of clinicians interested in budgeting and costs and so on to there being a much more general feeling that these things are important. (CCD4O)

The greater enthusiasm of surgeons for management is borne out by the differential take-up of the post of medical director³ (the doctor who leads the group of clinical directors and who sits on the Trust management board) between surgeons and physicians.

³ The title of medical director does not reflect any links with the medical specialization—as opposed to the surgical one—but is merely as a generic term to indicate affiliation with clinical activity rather than, for example, finance.

It's funny but all the medical directors in Scotland are surgeons, I know because they are all my friends. That's except our medical director and he has only just started, he is the one exception. (BCD1S)

MANAGING SURGERY AND MEDICINE DIFFERENTLY

The field of management has been characterized by two competing modes of professional knowledge. First, managers have been seen as technicians, who derive their knowledge from the principles and practice of management science and, second, managers have been perceived as exponents of a craft (or art) of managing that cannot be reduced to theories and explicit principles (Schon 1991, p. 236). Hence, management, as medicine, can be seen as a practice that is part science, part art (see the earlier discussion). These perceptions suggest that the scientific practice of management is more suited to surgery whereas the art of management looks to be more appropriate to medicine. The scientific practice of management—in terms of techniques to promote organizational efficiency, value for money, and accountable performances has already enjoyed more acceptance in surgery than in medicine. The following quotes demonstrate a favorable response from surgeons to these management techniques.

I've always had an interest in the efficient delivery of services since my registrar days and when I became a consultant I started to sit on a few little committees to get things agreed and sorted out—organized—I like things to be organized. (CCD4O)

This place is properly managed now, a lot of driftwood has been cast out, this was traditionally a place for passengers and there were a lot of hangers-on and a succession of managers got rid of them. Now we are getting value for money on all areas. (BCD1S)

There has been a very similar trend [to more accountability] on audit. It used to be that some clinicians who were interested in research and publishing papers would audit one little project but now everyone is more aware that clinical actions have a more empirical element and there is a much more general willingness to question what everyone is doing. (CCD4O)

The surgical directorates had been more amenable to rationalization than the medical ones.

The surgical directorate reorganised their wards to create an acute admissions ward and we wanted the medical directorate to do the same thing but it hasn't happened. It would have speeded things up and reduced length of stay for acute admissions by concentrating resources. Also it would have created opportunities to upskill nursing staff and release junior medical time. (CCD3SU)

In the surgical directorate a decision was made to appoint a specialist urology nurse and at the same time they did away with a few surgical beds. Now that's appropriate but I'm not sure that everyone goes about things in the same way. It's about the perception that you have to reduce a service in order to expand on something else, the surgical directorate grasped that issue a lot quicker than the medical. (CCD3SU)

Surgeons were more likely to recognize that although clinical judgement has to be paramount in such issues as the timing of patient discharges,

The problem is that there is a risk management aspect, the doctor takes the decision as to whether it is safe to discharge and if anyone questions their judgement a doctor will say well if you are asking me to discharge earlier then you [the Trust] will have to take responsibility and, of course, they [Trust management] won't want to do that. It's in this way that clinical things always take precedence over management things. (BCD1S)

there can be some agreement between doctors and managers in terms of the overall trend to higher activity and throughput.

But there as been symbiosis [between clinicians and managers] and it's changed the way we work. There has been a 40% increase in workload over the last 5 years and the average length of stay has dropped from 7 to 4 days. Now if anyone had asked if that was attainable 6 out of 7 clinicians would have said "No." People wouldn't move from entrenched positions which was bad. (BCD3S)

Moreover the "symbiosis" between doctors and managers extends to a generalized approach to problem solving.

I went on a course for middle managers, we were all from different backgrounds but we had the same problems—how to control costs, deciding how much to spend on IT and still get a pay-back and how to motivate staff. (CCD4S)

Surgeons also anticipated some advantage to the practice of surgery from the managerial techniques of centralized control and performance evaluation.

In the place of Trusts we should have a managed care model, in this context we could persuade people that it is a good idea to centralize. This way we would overcome the technical variation between surgeons and, potentially we could introduce certifications of competence. We should concentrate resources on high tech procedures to give quality, we should support specialist surgeons and we should prioritize health care. (ACD1S)

Scientific management (or Taylorism) is equated with standardization, centralization and bureaucratization (Walby & Greenwell 1994b). Surgery indicates its receptivity to scientific management through being amenable to these processes. In contrast the prospects for managing medicine in these ways are not promising. If medicine is to be managed, management as an art rather than a science looks to be the way forward. So far the response from physicians to the science of management has been muted.

IMPLICATIONS AND CONCLUDING COMMENTS

Professional work derives from long training, is driven by custom and practice, and is autonomous in direction; it has long been recognized that such characteristics make professional work difficult to manage (Mintzberg 1983). Consequent upon confronting these difficulties, the clinical directorate structure was introduced in the UK to imbue senior medical professionals with more managerialist values and attitudes, to manage doctors from the "inside" (Hunter 1992; Ezzamel & Willmott 1993; Jones & Dewing 1997). Management of the medical profession from the "outside" having had been deemed a failure (Pollitt *et al.* 1988; Preston *et al.* 1992; Harrison & Pollitt 1994). Attempts to manage the medical profession from the outside had never been promising as managers require at least the tacit support of a high proportion of senior doctors—as it is only through the actions of senior clinicians that the aims of management can be realized (Ackroyd 1996). The potentiality for extending managerialism into the clinical realm has always been there as management is a generic discourse. As such a management ethos can permeate the conduct of many different organizational actors, rather than being limited to a sub-set of actors—called management (Walby & Greenwell 1994b; Du Gay *et al.* 1996).

This paper has argued that managerialism sits more easily with surgeons and surgical work than with physicians and medical work. The articulation between surgery and management looks closer as the "entry points" (Amariglio *et al.* 1993), or central organizing ideas, of the two domains are more similar. Therefore "forms of receptivity" (Power 1994) to management are easier to establish in surgery. Previous studies in this health area have found that the development of clinical directorates is incomplete (Jones & Dewing 1997). This finding being a particular instance of the more generalized conclusion than in health (and in the public sector more widely) "...managerialism's impact is uneven and remains open to contestation, negotiation and resistance." (Clarke *et al.* 1994). Surgery is more easily analyzed as a rational scientific process involving the transformation of inputs into outputs, than is medicine, and, consequently the management categories of efficiency and productivity are easier to establish. This implies that the "labour cost-productivity equation" (Langan & Clarke 1994) is more readily established in surgery, and, once understood, this relationship can, at least potentially, be enhanced. Medicine, in contrast, is not as transparent as surgery and, therefore, is not open to transformation in terms of scientific management. The "arts" of management look to be more appropriate in medicine, where physicians are inspired to strive for excellence and the production of quality health care. If scientific management continues to penetrate surgery and the art of

management starts to be more systematically applied in medicine, what consequences may be anticipated?

Surgeons look to be better positioned in terms of demonstrating their resource requirements—at least in terms of the categories that managers revere—for example, those of productivity and efficiency. Doctors have tended to argue their case for more resources through “shroud waving” (Harrison & Pollitt 1994) *i.e.* advocacy based on worse case scenarios for patients if more monies are not forthcoming. As with other organizations in the public sector, health care has traditionally put forward a case for more resources on the basis of poor results, “Since needs are not being satisfied, quality is not high enough and the money is finished, more is obviously needed.” (Brunsson 1994, p. 326). Unlike in the private sector, where good results have to be demonstrated in order to elicit more resources, the paradox of soliciting for monies in the public sector has been that under performance has been the key. Surgery looks to be able to break out of this mode through demonstrations of technical efficiency (in the sense of the optimal relationship of inputs to outputs). But policy-makers in health care have also been concerned to enhance allocative efficiency—to ensure that resources flow to those who can make best use of them. There has been a policy across the Western world to transfer resources away from acute services (most often surgery) to primary care and preventative medicine but this intent has not been fully realized (Day & Klein 1987; Llewellyn 1997). Surgeons have been more amenable to making their work transparent to management, this response may, in part, be consequent upon this threat of resource loss. In this study the expectations of the medical specializations that more monies would be made available to them in transfers from the surgical directorates (see earlier discussion) were not met. If demonstrations of technical efficiency become paramount in resource allocations then medicine looks to be at a continuing disadvantage.

On the other hand medicine may be more able to avoid cost constraint measures by being less transparent to managerialism than surgery. This study indicated that the medical directorates had so far been more successful in resisting budgetary pressures and the rationalization of practice than the surgical ones. Previous research has indicated that cost variability is greater in medicine than in surgery (Llewellyn *et al.* 1998). As argued earlier in this article, this cost variability may be seen as consequent upon the greater inherent uncertainty in medical practice. One facet of professionalization has always the license to exercise judgement in uncertain domains (Scott & Meyer 1994, p. 222). Consequently trends toward the deprofessionalization of certain groups have been linked with processes of rationalization and bureaucratization (Murphy 1990). In this respect medicine looks to be more stable as a highly regarded professional domain than does surgery. Moreover, if the science of management is seen to have failed, the art of management may come to the fore in medicine. The art of managing, as developed throughout the 1980s, emphasizes human resource development, total quality and the pursuit of excellence (du Gay *et al.* 1996). The exercise of such strategies may result in professional standards being more enhanced in medicine than in surgery.

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